Wednesday, 14 May 2025

(10.00 am)

LADY SMITH: Good morning, and welcome back to our hearings in relation to Phase 9 that covers institutions providing for children with healthcare, additional support and disability needs. We move to the penultimate day in this section of the phase and I think we have a witness ready, do we, Ms Innes?

MS INNES: We do, my Lady. The witness this morning is Hannah Coleman, Director of Regulation from the SSSC.

As your Ladyship is aware, the SSSC have given evidence to the Inquiry on a number of previous occasions: on Day 212 in relation to the Boarding Schools case study, that was 18 March 2021; on Day 280 in relation to Foster Care, that was 10 May 2022; and on Day 371 in the Secure Care case study, that was 21 September 2023.

LADY SMITH: Thank you very much.

Hannah Coleman (sworn)

LADY SMITH: How would you like me to address you? I'm happy to use first name or your second name, whichever would work.

A. First name's fine, thank you.

LADY SMITH: Thank you, Hannah.

Welcome to the Inquiry and my thanks to you and your

organisation for all the assistance you've given us so far. I know that boarding schools, foster care and our secure establishments have already caused you to engage with us and do quite a bit of work to that end.

You know we're now in a different phase and I'm grateful to you for coming along now to help with that.

Your documents that you've provided to us are in the red folder in front of you. And we'll bring documents up on screen, we'll bring material up on screen from time to time, as is required.

If you've got any questions at any time, please just say. If you need a break, just tell me. We'll break at 11.30 am in any event if you're still giving evidence at that point, but any other time, it's not a problem if you need it.

A. Thank you.

LADY SMITH: If you don't have any questions at the moment, Hannah, I'll hand over to Ms Innes and she'll take it from there.

MS INNES: Thank you, my Lady.

Questions by Ms Innes

MS INNES: Good morning, Hannah.

A. Good morning.

Q. You provided a copy of your CV to the Inquiry and we can

see from that that you qualified as a solicitor in 2005; is that right?

A. That's correct, yes.

Q. Thereafter, you worked briefly in private practice and then you worked for seven years as a children's reporter?

A. Yes, that's correct.

Q. You joined the SSSC in 2014 as a senior solicitor in the fitness-to-practise department?

A. I did.

Q. You progressed through the SSSC and ultimately, in March 2023, you became Acting Director of Regulation?

A. That's correct.

Q. You were confirmed in that post, I think, in February of this year?

A. Yes, that's right.

Q. The SSSC have provided a report for this phase of the Inquiry's work and it's at SSC-000000091. If we can go to page 2 of that, please.

If we go down to paragraph 3, we can see, as you've told us on previous occasions, that the SSSC is a statutory body responsible for registering and regulating social service workers to protect and enhance the safety and welfare of people who use services. As part of meeting that responsibility, the SSSC has to set

standards in respect of practice, conduct and training et cetera?

A. That's correct, yes.

Q. In terms of this phase of the Inquiry's work, at paragraph 5, you refer to certain registered workers who are relevant to this phase of the Inquiry?

A. Yes.

Q. You say that they're social workers, school care accommodation workers and residential childcare workers?

A. Yes.

Q. Then going on over the page, and on to page 4, you tell us a bit more about the descriptions of these workers, particularly residential childcare workers and residential school care accommodation workers.

A. Yes.

Q. The SSSC have already given evidence about these categories. Since you last gave evidence in 2023, have there been any changes in respect of these categories or not?

A. Not in respect of the categories as such, but in respect of how we categorise them with the SSSC, where they used to be registered on our register as one of 23 register parts, so the individual titles you see there, for example, residential childcare workers, a manager in residential childcare, that used to be one of our

register parts.

In June of last year, we carried out -- we concluded a large programme of work, which was implementing a lot of changes and improvements to our organisation, one of which was to simplify our register. So we now have four register parts, which are: social workers; student social workers; adult social care; and children and young people workers. So those workers within residential childcare and residential school care accommodation now sit within that one register part of children and young people workers.

Below that and behind the scenes, we still retain the level of detail as to the service they're working in and the level of their role, but what it means is it simplifies things when they are promoted or when they change roles within that same register part, they no longer have to come off our register and then re-apply to new parts, whereas now --now they just have to tell us of a change behind the scenes and they remain on that one register part. So fundamentally no changes as such, but in terms of how our register is structured, there has been that change.

Q. Okay, and at paragraph 8, you refer to the Registration of Social Workers and Social Service Workers in Care Services Regulations 2013, which make it an offence for

a provider of a care service to employ an unregistered social worker or social service worker in a role subject to required registration.

When you last gave evidence in 2023, you told us that there was a proposal to change the grace period for registration from what was then six months to three months. Has that happened?

A. That has. So there is a new order that was brought in in 2024 to make some amendments to the 2013 regulations, so now an individual has to apply for registration within three months, then the application has to be -- they have to obtain their registration within six months. So obtaining remains at six months, but previously the order said that they had to apply as soon as is reasonably practicable which, in reality, meant it could be closer to the six-month mark, whereas now it is an offence if an employer is employing somebody in that role who has not applied within three months. We, as an organisation, then have three months to process that application, although our application times are currently just over three weeks as at today's date, so they're much shorter than that generally.

LADY SMITH: So, just for the transcript, that's from start of employment in that role?

A. Yes.

LADY SMITH: In the registrable role?
A. Registrable role, exactly.
MS INNES: You said that came in in 2024 and does it apply to anybody new coming on to the register, as it were, after that date?
A. Yes. It applies to anybody starting in their role on or after 3 June 2024. Those prior to that would have six months -- the previous rules would apply, the six-month rule whereas now, as of June, it's three months.
Q. Now, if we go down to paragraph 9 on this page, you refer there to the statutory change to the structure of the register that you've just referred to, so the simplification of the register from the 23 parts to 4. Then you go on to explain that the workers relevant to the Inquiry sit under the children and young persons worker part of the register.

Then at paragraph 11, you go through the different parts of the register, when the register opened, when it became required and the numbers on the register?
A. Yes.
Q. So if we go on to the next page, page 5, there's a group of workers in the top part of the table, who are involved in a residential childcare service. The bottom part is a residential school care accommodation service?

A. Yes.
Q. In terms of the establishments that we're looking at in this phase of the Inquiry, where would the workers sit in this?
A. Generally they would sit within residential school care accommodation services, special schools is a category that falls under that part of the register, it's one of the three categories, so the majority of workers registered within residential school care accommodation are not relevant to this phase. It would be independent boarding schools and that category, but they're all within that same category included in that special schools.
LADY SMITH: So anything that presents itself as a school and has residential provision for children is in the same category, irrespective of whether it's the independent boarding school, of the sort we looked at in the Boarding School case study, or a boarding school that's making provision for particular needs that children have?
A. Yes, exactly. They're all in the same category. So it's not broken down further than that within the register parts that we have, so it does encompass all of those individuals.
MS INNES: You mentioned that there were three types of

school within this.
A. Yes.
Q. You said special schools and independent schools?
A. There are -- I think in terms of the legislation, there is special schools -- there's hostels to enable them to attend school, so I think that comes under independent boarding schools as well, is my understanding, and then independent schools themselves, so I think that -- as I've said, it's broken down in three in terms of legislation but as we would provide, it would be two that we would really consider.
LADY SMITH: So the hostels you are referring to would be, for example, in some places in the west of Scotland, there's a hostel on the mainland to enable --
A. I think so -- yes.
LADY SMITH: -- a child from the islands to attend a day school on the mainland?
A. Exactly -- exactly yes. Yes, so not independent schools but, yes, related to that school accommodation provision but not within that -- not encompassing the special needs provision as we're looking at for special schools.
LADY SMITH: Because the hostel will be run separately from the school --
A. From the school, it would, yes, yes.
LADY SMITH: -- but linked to the school?

A. Exactly.
MS INNES: So looking at the categories there in respect of school care accommodation services, you've broken it down to managers, supervisors and practitioners. You've indicated that in respect of managers, the register first opened in November 2009 and it became a requirement in November 2012.
A. Yes.
Q. Then in respect of supervisors and practitioners, the register opened in 2010 and then for supervisors, it became compulsory in April 2013 and for practitioners in November 2013?
A. Yes, that's correct.
Q. In terms of the Inquiry's terms of reference, looking up to December 2014, there's a relatively short window in respect of these workers when the SSSC would have been involved in fitness-to-practise investigations, for example?
A. Yes, yes.
Q. Then if we look over at the numbers of people registered under each of these different categories, are these the numbers on the register as at the date of this report, which I think was January of this year?
A. That's correct, yes.
Q. We can see that there are comparatively few workers

registered under school care accommodation services as opposed to residential childcare services?

A. Yes, there are a much greater number of residential childcare services than school care accommodation services.

Q. Residential childcare services would include children's homes and local authority-run establishments --

A. Yes, yes.

Q. -- and suchlike? Okay.

Looking at the percentage of those who are qualified, just in this table, if we look at 'Manager of a residential school care accommodation services', we have got 24 as at January of this year, 41.7 per cent are qualified. I think that would be about 10, roughly. So that would suggest that 14 aren't qualified.

Do you have any comment on the proportion of qualification in that category?

A. Yes. Yes, obviously the proportion is lower than you might hope to see in terms of qualification rates. A couple of things to say on that.

The first is that we've been doing some work looking at what we'd expect to be the maximum rates of people qualified within particular parts of the sector, based on the information that we hold about turnover within that part of the sector and people then having to come

in to fill empty roles and then having a period of time in which to obtain their qualifications. So we haven't broken it down into the categories that we're looking at here. But for the overall part of children and young people, we understand the maximum possible qualification rate to be around 74 per cent currently. So still significantly higher than we're seeing there, but it isn't 100 per cent, because that wouldn't be achievable due to turnover and people starting within roles who normally would not start with the required qualifications.

The second point possibly to note is that prior to June last year, everyone who was -- everyone in a function-based role, so other than social workers, all of those applying to be registered with us have to obtain a qualification which they can gain while they are working. And they were given five years to obtain those qualifications. We've now implemented changes for most parts to reduce that down to three years. So any managers starting in a role on or after 3 June last year will now have a period of just three years to obtain their qualification, whereas those starting in a role prior to that would still have five years to obtain that qualification. So we hope to see an increase in qualification rates over the next couple of years as

that improves -- that timescale reduces.

Q. Are the required qualifications for a manager different from the required qualifications for a supervisor or are they the same?

A. They are the same, in that they are both an SCQF, a Scottish Credit Qualification Framework Level 9 qualification that they have to obtain, which I think my understanding is takes around two years to obtain.

Q. Is there any difference between what a manager and a supervisor has to obtain from a practitioner?

A. Yes, a practitioner is actually -- and apologies, I should have pointed this out earlier as one of the changes, prior to June last year we had support workers rather than practitioners within residential childcare and school care accommodation services but as part of that work that we were doing, the wholescale review, we identified that those working at that level within residential childcare and residential school care, the scope of their roles was actually akin to that of a practitioner so we no longer have the support worker role, we now have the practitioner role.

For practitioners, it's a Level 7 -- an SCQF Level 7 qualification to obtain, rather than a Level 9. Now, for those working at that level, practitioner level, they have to obtain two qualifications. Often they will

have one qualification when they start, so they'd have to obtain a second qualification within three years, but if they started within their role and had no qualification, they would have to obtain two qualifications and we would give them five years to do that.

That's for residential childcare and residential school care accommodation for only those working in special schools, so those working within independent boarding schools have one qualification to obtain and three years to obtain that. So it was reflective of the environment in which residential school care accommodation special schools is and the additional level of experience, expertise, skills and knowledge required for that specific role.

So there's two qualifications required for that part.

Q. If we just look at this just now on page 6, at paragraph 16, you say there:

'The relevant practice area for the Level 7 award for those working in secure or residential care ...'

And you refer to that and then you say that there's a core unit in relation to promoting and safeguarding children and young people and then there's another core unit promoting effective communication. Are those core

units the ones that you are referring to or is it something different?

A. There's four core units within every qualification and actually within different levels, they're the same core units that cover and the two that are set out there, it says 'promoting safeguarding', there is communication, health and safety and reflective practice, so those are the same four core units whether it's a Level 7 or a Level 9, but the detail would be at a different level so it's the fact there's --

The bottom part of that table has a practice requirement and a certificated knowledge requirement. So there's two separate qualifications that are required to be obtained. Both at Level 7, but both of those have to be obtained for that part.

Q. Okay, and what's the difference then between that, in this context, so for special schools, and independent schools?

A. Independent schools would not require the certificated knowledge element, they would just require the practice element.

Q. What's the difference between practice qualification and certificated knowledge?

A. Practice -- my understanding is the practice-based element is the part that would be predominantly carried

out within the workplace using workplace examples and that really sort of practical element and then there's the certificated knowledge element that would be the more -- the less practical and more --

Q. Theoretical?

A. Yes, thank you, written evidence rather than the practice-based element that is more focused on being within the workplace, that's my understanding.

Q. Going back to page 5 and back to the table, when we're looking at the practitioner in a residential school care accommodation service, we see that 46.2 per cent are qualified. You mentioned a moment ago in your evidence that there had been support workers and practitioners and they'd been amalgamated? No?

A. Apologies, no, previously there was no practitioner level, it was just a support level, so it was a support worker, then it was supervisor and manager. So now it's just practitioner, supervisor and manager. So only ever three levels, it was just recognising that the role of a support worker within residential childcare or school care wasn't really appropriate, they were working at that more senior practitioner level.

Q. Did that then have an impact on the qualifications that these workers should have?

A. No, the support worker also had to obtain an SCQF

Level 7, so it wasn't an additional requirement placed on them.

Q. Okay. Just bear with me a moment.

In terms of the reduction in the period required for qualification, have you seen any impact in relation to that yet or because it's a gradual process?

A. Not yet, because it was just implemented on 3 June last year so anyone starting in a role from that point will have three years. We are seeing a slight increase, a gradual increase in qualifications being obtained, but it's too early to see the improvement as a result of that reduction. We would expect that to take the best part of those three years before we saw that coming through.

Q. What happens if somebody doesn't get the qualification within the required period of time?

A. That's something we would look at on an individual basis. We have the ability to extend the period by which somebody has to obtain their qualifications, so if, for example, somebody had been on maternity leave and was able to confirm that, we would extend their period to obtain qualifications. It's very much looked at on an individual facts and circumstances basis, there would not be a blanket extension given. There was during COVID times because of the complications then,

but that's not what we do now. Currently, and prior to that, we look at every case on an individual basis and if there was no reasonable reason for somebody not having obtained their qualification and they were not already mid-way through obtaining that, then we would remove somebody from the register if they had not obtained that within the timescales.

Q. Do you think that the extension given during COVID times might have an impact or might have had an impact on the level of qualification that we're seeing?

A. Yes, I think because of the challenging times at that period, back in 2020, there were people who were -- everyone was given an extension at that stage. We weren't chasing up qualifications at that time, so it has had a bit of a knock-on effect but I think being now in 2025, that impact should have diminished quite greatly. Normally people would have been given an additional year to obtain their qualifications, so that should by now have worked it's way through so that shouldn't be impacting those figures we're seeing today.

LADY SMITH: Are you saying that the COVID extensions, Hannah, were generally a year?

A. Yes.

LADY SMITH: Was that a blanket decision or was that still being assessed on an individual basis?

A. My recollection is that was a blanket decision because of the challenges being faced by the sector at that time, so if qualifications -- if we hadn't received notification of qualifications, I think we did not want to put additional pressure on services by asking them for additional information at that time. So I recall there was a blanket extension given at that point of I think it was 12 months. I could check that, clarify if that would be helpful.

LADY SMITH: No, that's okay.

But that would mean -- I don't suppose you'd be checking -- that individuals would be working perhaps for a full year longer than they would otherwise have been allowed to work on an unqualified basis?

A. Yes, yes. At that time, yes.

LADY SMITH: Thank you.

MS INNES: If we can go down on to page 6 to the final paragraph there, paragraph 17, you refer there to evidence given in Phase 8, so that's the last time that you gave evidence in 2023, and you referred in your evidence then to the development of the Standard of Residential Child Care and at the time it hadn't been implemented, has it been implemented since?

A. It has not. The position from our perspective remains unchanged since that period. We are still in touch with

Scottish Government about that. Our understanding is that they're still supportive of implementing that, but we have not been given a timescale for when that is to be implemented.

Q. We also know that there was a standard in respect of foster care. Has that been implemented?

A. I'm not sure about the foster care. Apologies, I can check that and let you know if that would be helpful.

Q. Okay.

You then, at paragraph 19, on page 7, you set out the current qualification level of different parts of the workforce, but these are all of the different parts that you regulate?

A. Yes.

Q. We see, for example, residential childcare services I think at 48.18 per cent?

A. Yes.

Q. And residential school care accommodation at 46.44 per cent?

A. Yes.

Q. But we've seen a more detailed breakdown of that in the previous table?

A. Yes.

Q. Then you go on to refer to codes of practice, common core and then over the page to corporate parent.

I think these are all matters that you covered in your evidence on the last occasion?

A. Yes, that's correct. Other than, I suppose, we published our further -- I think at the point of the last giving of evidence, the codes were still at the draft stage, the new codes which were published in May of last year, so those are now operational, the new codes of practice.

Q. I want to look at another document that you gave us --

LADY SMITH: Sorry, when were the new codes published?

A. It was May 2024.

LADY SMITH: Thank you.

MS INNES: We obviously know that UNCRC has been incorporated.

A. Yes.

Q. I want to ask you now about the impact of that on the SSSC's work and I wonder if we can look, please, at SSC-000000092. This, I think, is an email from you setting out the various actions that you've taken since incorporation.

A. Yes.

Q. If we can go through that. You say -- you have just referred to it there -- that you published revised codes of practice in May 2024. How did UNCRC impact on the codes of practice?

A. That was taken into account in the consultation that we did and the consideration we gave to how these should be redrafted to accord with our obligations there, and I think I've mentioned in the email, one of the codes introduced the language of kindness and compassion in keeping with The Promise and UNCRC. I think -- I understand that that was possibly discussed at the last time that evidence was given and there had been a bit of conversation internally about whether that was a correct part of the codes to have in, given the fitness-to-practise concerns around how that might then be evidenced.

But it was felt in discussion and consultation that that was a really important part of the codes. That was the voice that was coming through in the consultation, that that was what was really needed. One of the things that was needed to be included in the codes, so that now forms part of the new codes.

As I've said, they were retained -- there was this strong language that again I think was discussed when we last gave evidence. The codes have been reframed and generally are in a positive form as an 'I will', 'What I will do', and there was discussion around code 6 retaining that 'I must not', so when it's relating to must not abuse, must not exploit, the serious behaviours

there, we have retained that language there.

Also in terms of children's voice, making sure that relationships are built, that children's voices are built into those relationships and their ability to make decisions and to take risks as appropriate within -- as with all users of services, but in particular with UNCRC that would relate to obviously children.

Q. Then in the next bullet point you refer to having published a learning resource for people working with children and young people to support them to use the codes of practice, the principles of UNCRC and The Promise. Can you tell us a bit more about that, please?

A. Yes, that was a resource that was published just in April. It looks at those three things, it looks at our new codes of practice, it looks at the UNCRC and it looks at The Promise and it is a resource that's really designed not for children but to be used by workers who are working with children to help them understand those three elements and how they might engage those in their work with children.

So the resource itself has written parts to it, it has a podcast but it has videos to watch, all setting out what those obligations and rights look like and how workers might use that in their day-to-day practice and engage with children to make sure that the children's

rights are being upheld. So that was just launched in April.

Q. Then you say in the next bullet point that you are leading work on behalf of Scottish Government to refresh the common core for the children's workforce and you say that that will include the UNCRC as an underpinning value.

You have already given evidence about the common core, but this is refreshing it and can you tell us about the work that is being done in relation to that and the impact of UNCRC?

A. Yes, the common core, I think, was last refreshed in 2016, so this is a refresh that, as you've said, we are leading on and that would be concluded by the end of this year: December 2025 is the date for concluding that.

We have engaged the voices of children as part of the consultation work and the ongoing work in relation to that, in that we work with a number of organisations who engage directly with children so we're able to obtain information from them, such as Children's Hearings Scotland are one of the partners that we've worked with in relation to this, so this is the first part, the common core will be -- yeah, will be refreshed by the end of the -- no, apologies, I'm thinking of the

National Occupational Standards at the end of the year, the common core work has concluded. It's going to the relevant group for sign-off in August, so that should be concluded by the end of the summer.

Q. You refer there to engagement with organisations who work with children. Just thinking about the children that we're thinking about in this case study, so children with disabilities or additional support needs, to what extent has there been engagement either with them or with organisations who work in that area?

A. Yeah. My understanding is we haven't as an organisation engaged directly with children, but we have engaged with a variety of organisations. I can't recall the number of organisations, but my understanding is we would have sought to obtain a wide range of views for all children that would be impacted by this, through that engagement with the overarching groups who have that direct contact with them.

Q. Then you mentioned that a moment ago, the review of the National Occupational Standards, can you tell us a bit more about the work going on in relation to that?

A. Yes, so again we're involved in that work and that was a piece of work that I was saying will be concluded by the end of December this year, so that work is in hand.

Again, I've highlighted in my email there, there's

some skills gaps that are currently missing from the occupational standards such as trauma-informed practice, which we're aware of the importance of that. That's something we've introduced in our new codes and also are looking at in relation to the National Occupational Standards. Again, in terms of holding and promoting rights to compassionate care and again what comes out of The Promise, we're trying to embed all of that in the National Occupational Standards.

Now, they'll conclude at the end of this year and then in 2026, there'll be a review of all qualifications that relate to the National Occupational Standards, so all qualifications that the SSSC require individuals to obtain are based on the National Occupational Standards. So once they have been reviewed, there will be a year-long piece of work that reviews all of those qualifications to make sure they reflect the current updated National Occupational Standards and then the following year, those will then be rolled out into 2027 in relation to those changes to qualifications as required.

Q. You mentioned there, 'We're working with our UK sector skills partners'.

A. Yes.

Q. Are the National Occupational Standards UK wide?

A. They are. They are. So they're used by each of the four countries, I suspect in slightly different ways, but in Scotland we have them underpinning all of our qualifications.

Q. The final bullet point on this page, you refer to your new model of continuous professional learning introduced in June 2024, having mandatory skills and knowledge requirements on trauma awareness and child and adult protection.

Is that internal learning or is that learning in respect of the workers that you regulate?

A. That's in respect of the workers that we regulate, so they have continuous professional learning requirements. The fact there are continuous professional learning, CPL, requirements in itself is not new but what we have done is revamped the model for how we do that. So previously it was very much based on a number of hours that had to be obtained, whereas now we've moved away from a specific number of hours to areas of practice that have to be covered.

There's a number of areas of practice that have to be covered, but there are three mandatory areas -- three mandatory skills and knowledge requirements there and that is, as you say, is trauma awareness and child and adult protection. Beyond that, it will depend on the

role somebody has and the level at which they're working and the stage of their career that they're at in terms of what CPL that they do, but that can be resources. We have a huge number of free resources, but it may be that employers support individuals to do their CPL internally as well, and then we sample that to test the CPL that is being carried out. That will be rolled out, the sampling, as of June this year.

Q. For all of the workers that you regulate, they have to undertake mandatory courses on trauma awareness and child and adult protection?

A. Yes.

Q. Every year?

A. Every year.

LADY SMITH: But you're no longer dictating the number of hours they must spend?

A. No.

MS INNES: If we go on over the page, please, you refer to having updated your complaints handling procedure, which has guidance for staff and you say that's been updated to reflect the Scottish Public Service Ombudsman child friendly complaints handling procedure, which was issued in July 2024. You say that this is about helping organisations implement the model complaints handling procedure in a way that upholds children's rights under

the UNCRC.

Would this be for children making complaints directly to you about the work that you're doing?

A. Yes, children making complaints directly or people making complaints on behalf of children, so trying to encompass both of those things; if a child wants to directly complain to us but recognising they may not be able to do that, so they may have somebody else make that complaint on their behalf, but fundamentally it's still coming from that child so just to make sure that we have processes in place to manage that.

Q. It's in respect of complaints about the work of the SSSC as opposed to organisations?

A. Yes. We internally talk about 'referrals', which are referrals relating to workers and 'complaints', which are complaints about the SSSC. So this is complaints handling procedure related to, yeah, complaints about us as an organisation.

Q. Then you go on to refer to some new guidance you've published in relation to employment of 16- and 17-year-olds. Then on the next bullet point you say:

'We're exploring how we can do more around easy read and inclusive communication, with staff having recently undergone detailed training in this so that we can produce resources internally.'

Are you able to explain that further?

A. Yes, so a couple of things we're doing in terms of that easy read sort of accessibility point. We're about to launch a new website, which is going to be more accessible than our previous website. We are aware that our previous website had limitations in that respect, so we're making improvements in that regard.

But in relation to easy read, it is that production of a second copy of a document so you have your standard report and then it's that simplified version that's an easy read version that's better for children or certain adults to use, that is quite a resource-intensive piece of work to provide those additional pieces of guidance. Previously we have outsourced them, but we now have a number of staff internally trained so we produce a massive amount of documentation, so we're trying to prioritise and work out which of these documents are more likely to be needed in easy read format and will target those first, so we will prepare them, so things like guidance on making a referral to the SSSC is one of the ones we're looking at first as an example, and then we'll work through those.

LADY SMITH: Hannah, do you receive complaints directly from children about SSSC or from adults on behalf of

children?
A. I'd dug into this. Since we made the change in July 2024, we don't think we have received any complaints from children or on behalf of children as yet. We may do in the future but that's not something in terms of in relation to the SSSC, no.
LADY SMITH: Were you receiving them before July 2024?
A. We didn't have a way of recording that, so that's not something -- we're looking at recording that going forward so we're able to keep a better track of that, but I'm not sure if we received anything prior to July 2024.
LADY SMITH: I just wonder whether in reality the vast majority of children or even adults who might complain on their behalf are aware of the part played by SSSC and would ever think of complaining to them?
A. Yes, possibly not. Perhaps we've more to do in terms of that awareness-raising piece rather than just the guidance itself, yes.
LADY SMITH: Thank you.
Ms Innes.
MS INNES: Thank you, my Lady.
If we move down to the bullet point beginning:
'All employees must complete a mandatory course on children's rights.'

Is this something new for your staff or not?

A. Yes. This was introduced, I think, last year and that was one of the mandatory pieces of training that we require all staff to complete.

Q. That would follow on the incorporation of UNCRC?

A. Yes, it did, exactly, and it relates to the UNCRC and it talks about that in the training, it's directly related to that.

Q. Then in the next bullet point you say:

'We are working to secure an advocacy and intermediary service for fitness-to-practise witnesses and members of the public who make referrals to the SSSC.'

Can you explain that, please?

A. Yes, so advocacy, not as in courtroom advocacy but as in that ability to assist people make those referrals, so we are conscious that there are people who may struggle to articulate themselves and to give us the information we need to receive as a referral to be able to do something about that.

There was consideration of an advocacy service, I think, as part of the National Care Service work that was ongoing, so we had been waiting to see if something was going to come in on that basis. It still looks like that's maybe a possibility in terms of the regulation,

is what I understand, but given the time that's taking, we are now looking at that internally to see what we can secure and provide ourselves in the way that some other regulators do. So to be able to support people to first of all make those referrals to us but then support them through the process, so if they need to come along and give evidence eventually or with witness statements, they could be supported throughout that process. So that's something we're looking into at the moment.

Q. Then the final bullet point you note that you will be required to produce a report every three years --

A. Yes.

Q. -- covering certain issues, essentially covering actions taken to ensure compatibility with the UNCRC requirements and suchlike. I think the first report will be due as soon as practicable, you say, after the end of the reporting period, which ends on 31 March next year?

A. Next year, that's right, yes.

Q. If we can move back, please, to your main report at SSC-000000091. If we look at page 8, under the heading, 'Fitness to practise'.

You refer at paragraph 24 to the interaction between the SSSC and Disclosure Scotland. You have previously provided evidence in relation to this and if we go down

to paragraph 27, you set out there the process and interaction with Disclosure Scotland.

First of all, if we're looking at the time of registration, at point (b), you say there that a worker who applies for registration with the SSSC will provide their PVG scheme record number and give details of any conviction or other relevant information contained on the scheme record, which is a PVG scheme record.

Does that still apply or not?

A. We no longer ask workers to provide their PVG scheme record number, as that's not something we are able to use, but we do -- everything else still stands, so essentially the employer will obtain the PVG -- they'll obtain the PVG, they will then countersign somebody's application, which confirms whether they have declared offences that have been shown in the PVG certificate for example.

The exception to that would be where we apply for PVGs ourself for workers. It's a very small number of workers, but we as an organisation apply for PVG records for student social workers and for social workers who are not in employment, independent social workers or retired social workers who remain on our register but don't have an employer to carry that out PVG. We would carry out that as an organisation, so we would obtain

their full records in those cases.

Q. Would the employer send you a copy of the PVG with the application or not?

A. No, we wouldn't receive a copy of the PVG. The application requires an individual to declare disciplinaries, declare offences, declare lots of information on that. Their role as a countersignatory from the employer is to check all of that information and to countersign and confirm it is correct and part of that obligation is that they have cross-referenced that with the PVG certificate that they have and it is correct, so if there's anything showing on that PVG, it is included in the application. But we don't receive a copy of the certificate.

Q. What if an employer doesn't tell the truth or doesn't get the PVG but signs the form?

A. We wouldn't know about that. The duty of the employer is to disclose that to us, so we're not party to that so we don't receive those forms. On occasion we will. An individual can tick boxes as to who are interested parties. There's no obligation that they tick the SSSC, but they can. So they will then provide us with more information, but we will receive information from Disclosure Scotland if somebody is being considered for listing, so as at the point that happens, regardless of

anything else, the fact that we're a regulatory body and an individual is working within that sector, Disclosure would tell us about that, so that's not anything to do with us being an interested party or named on a certificate. It's just if somebody is working in a regulated role, they will let the relevant regulator know that somebody has either been considered for listing or indeed has been barred and then we can take action.

Q. So they would let you know if somebody is being considered for listing?

A. Yes.

Q. Do you keep a record of that?

A. Yes.

Q. Even if somebody isn't yet registered with you, and say they're doing something else and Disclosure Scotland are considering them for listing, would they tell you about that or not?

A. If they were working in a regulated role, they would tell us. So if they are working in a role that we're regulating, they would tell us that, 'We're registering', so they would tell us in those circumstances.

Q. You say that asking the worker for their PVG scheme record number was something that you previously did and

no longer do. Even when you got the PVG number, did you do anything with --

A. We didn't do anything with it. So it's an administrative process that has changed, but it hasn't actually changed the information that we receive.

Q. I suppose I'm just thinking about an incident where somebody has been considered for listing with Disclosure Scotland, they weren't in one of your regulated areas at the time, they go to an employer, the employer doesn't bother to get the PVG but ticks the form saying that it's been obtained. You would never know that they had been considered for listing?

A. In those circumstances, no, we wouldn't know, no. We would know if they were subsequently listed, so if they were barred, Disclosure Scotland obviously would tell us at that point, but we wouldn't know about the consideration for listing. But if we are notified of consideration for listing, we tend not to get any information with that, so we don't know the reason for the consideration, we just know that there is consideration being given to that.

Q. You talk about that over the page, on page 9, at subparagraph (h), when you say that Disclosure Scotland are only able to provide the reasons for consideration for listing in certain circumstances and this was

discussed the last time the SSSC gave evidence.

You say there:

'However, the SSSC is normally aware of the reasons, either from the employer or directly from the worker.'

I suppose if it's a new registration, you're not going to know about that and you're not going to know of the reasons unless you've been told by the employer or the worker?

A. Yes, yes. If it was a new applicant, we wouldn't know unless there was something declared on the application.

Q. At the end of this list, at (k) you say:

'In 2011, when the scheme was established, the Scottish Government wrote to regulatory bodies advising that they did not consider that it would be appropriate for regulatory bodies to make known the fact that an individual has been barred.'

Do you know why that was?

A. I don't know why that was, apologies. I can certainly look into that to see if I can get more information and send that on if that would be helpful to the Inquiry. My understanding is there was a letter. We've followed that. We don't publish that information, but I'm not sure of the detail behind that. I'm sorry.

Q. Okay, so what impact does that have on the information that you make public about a worker?

A. If we are removing somebody because they have been barred, we would not know the reasons for that barring. We would just know the fact that they had been listed by PVG. But we would not make that fact known, so on our register it would show an individual as having been removed but it would have no further detail as to why that was.

If somebody was removed by a Fitness to Practise Panel for example, there would be a detailed notice of decision setting out the allegations, the reason for behaviour, that notice will appear on that individual's entry in the register and it would be clear what those reasons were and what the behaviour was. But if somebody is removed for PVG and maybe in other circumstances there would be odd occasions in which somebody is removed, but there's no notice of decision with accompanying reasons published. So you would be able to search the register and see that individual had been removed, but you would have no further detail as to what the reasons for that were.

Q. If we look on to page 11, please, and under paragraph 32.1, there you are referring to information that you have given to the Inquiry in response to the Section 21 notice. If we look to the third bullet point you say:

'One case was removed for other reasons under our rules. There is no formal notice of decision for this case.'

So is this a person who was barred?

A. I think from memory, yes, it was a listing decision.

Q. Am I right in understanding that because of this instruction by the Scottish Government, that you considered that you couldn't speak publicly about the detail of that case?

A. Yes, albeit we wouldn't necessarily have any detail on the case. We would just receive information from them that a particular individual has been barred and that's all we would know. On the back of that, we would then remove them from our register, so unless we had an ongoing related investigation -- well, we wouldn't know if it was related, we may have had an open investigation at the time but no, we wouldn't have -- generally we wouldn't have any further detail on that.

Q. Do you think that any improvements could be made in the way that the SSSC interacts with disclosure?

A. I think generally the lack of information that we sometimes experience doesn't prevent us from taking action, so when we are aware of somebody being under consideration for listing but not of the reasons for that, we can almost always get that information from

either the individual themselves or from their employer, because they'll be aware of the circumstances.

If the employer is unaware of the circumstances, or there is no employer, or if the worker refuses to provide us with any further information, we can take action in terms of our rules to remove somebody on that basis for their failure to provide us with that information. So it doesn't prevent us taking action to maintain the integrity of our register just because somebody won't engage with us.

Q. If we could go back to page 9, please, paragraph 28, you say there:

'Our most recent data as at January 2025 on referral levels for fitness-to-practise shows that registrants working in childcare services comprise 3.65 per cent of the total Register and 9.48 per cent of the live fitness-to-practise caseload, and registrants working in residential school care accommodation comprise 0.18 per cent of the total Register and 0.25 per cent of the live fitness-to-practise caseload.'

It appears, particularly in relation to residential childcare services, those workers make a disproportionate contribution to fitness-to-practise investigations.

Do you know what the reason for that is?

A. Not categorically, but I think part of that will be down to the environment within which people are working in those settings, that there can be more challenging behaviours, there can be more incidents within a residential setting versus perhaps day care of children setting, so that can result in greater numbers of incidents which can result in referrals that come in.

Now, half of our referrals received across the board come from employers. About 20 per cent, I think, come from members of the public, which includes service users, it includes family members, it includes colleagues, so depending on the circumstances, it may be that referrals are received.

Now, those are just open fitness-to-practise cases. We impose a sanction in -- I think it is about 8 per cent of our cases currently, so 92 per cent of cases are closed with no sanction. So the fact that there are a certain percentage of live fitness-to-practise cases does not mean that there will be a disproportionate number of sanctions imposed, if that makes sense, it's just that referrals have been made and indeed cases are open in that respect.

Q. Do you use this data to any extent to try to analyse what's going on in the sector?

A. More widely, yes, that's something -- we're relatively

new to that. We're aware that we have a huge amount of data, so over the past perhaps, I think, year or so we've been doing a lot of work on the data that we hold. What we're trying to do is analyse the information, as you're asking about particular register parts, what trends are we seeing in relation to particular register parts, what behaviours are we seeing being referred and what can we do about that.

So there's an arm of the SSSC, our workforce, education and standards directorate, who are responsible for training and education. So what we're working on is having a much more joined-up approach so that we can learn from what we see within fitness-to-practise, identify those trends and identify gaps in training and learning and resources to fill them and we would target that to specific areas, because we're very aware the patterns that we see in, for example, residential childcare will be quite different to day care of children or care home services for adults, so they need to be targeted to the specific areas. So we are at a relatively early stage of that work. We just have that wealth of data and we are trying to drill down and work out what it is that we can do with that to make things better for the sector as a whole, but fundamentally for those who are using services because

we're identifying concerns and trying to do what we can to pre-empt them and prevent them from occurring.

LADY SMITH: Some of that work, I take it, will involve informing the sector of what the results of your interrogation of your own data might tell them about the way their sector is operating?

A. Apologies, I missed the first part of your question.

LADY SMITH: The point I'm trying to make is, the sector need to know what the results of your data interrogation are if they're going to be able to make any use of it to improve what they do, yes?

A. Yes, our intention is once we get to the point of having identified what the data about a particular part of the sector is telling us, that we will then target the resources to that part of the sector. We do quite a lot of engagement work with employers, with individuals, so we would then target that quite specifically and potentially that would be creating resources for individuals, but it might be resources for employers that they can use. It might be that we identify perhaps some things needed at an induction stage, or whatever that tells us, yes, engaging with the sector is key to achieving any sort of change.

LADY SMITH: Hannah, when you are talking about resources, what do you mean?

A. In that respect I'm talking about training and learning resources. So if, for example, we are identifying that there's a particular issue in residential childcare in relation to a particular type of behaviour, we're seeing something coming up regularly and referrals coming in for something that is coming up, and probably we're talking about maybe the lower-level behaviours that come up, because actually there are very serious behaviours that maybe you're less likely to address with training. Whereas actually it would be the lower levels things that we're seeing coming in as referrals but we are not necessarily taking action against but we're having to consider, are those things that we can target and we can develop specific training or learning resources, whether that's online learning or physical training sessions that could train people, help educate them to be aware of the sorts of challenges they might come across in their specific area of work and how they might modify their behaviours to prevent them becoming fitness-to-practise cases.

LADY SMITH: You are really talking about giving the employers information that you would expect them then to build into their training, are you?

A. Possibly, or actually pointing them in the direction of training resources that we've already developed and say:

'Here's resources tackling that that you can use. They're available on our website. Here's how you can access them.'

We've got a lot of resources that are all available free of charge on our website that employers can tap into, so it's really just to expand into that.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

At the bottom of page 9 and going on to page 10, you look at the various establishments falling within this case study, who you regulate or have regulated over the relevant time.

If we go on to page 10, we can see that Donaldson's was registered between December 2007 and it closed in 2017. I think that's because it no longer provides residential accommodation as of that date?

A. Yes.

Q. Then the Royal Blind School is the next establishment mentioned and there are various entities there. If we look down at number 4, we see that there was a service that was registered in April 2002 and closed in 2021 and that was a residential school care accommodation service?

A. Yes.

Q. Then if we look at 2, we see that a new service was registered in January 2021 and this was a care home service?
A. Yes.
Q. Do you know why that change was made?
A. I don't, no.
Q. Then we see that there was a separate service which is designated at Craigmillar and that was only on the register for a short period of time, 2002 to 2003?
A. Yes.
Q. Then you refer to Starley Hall School, which was registered in April 2002 and that's still active?
A. Yes.
Q. The next entry is Seamab and under there we have two services, Lendrick Muir School and Seamab, Lendrick Muir School being referred to as a school care accommodation service and Seamab being referred to as a care home service for children and young people.

It looks as though both of those services closed in 2019, but I think that Seamab do still have a service registered with you?
A. Yes. I think I've referred to them in my email that's possibly at document 92, I think, below the UNCRC information, there was a previous email that confirmed two further services that have opened latterly with

Seamab and remain operational.

Q. Okay, thank you.

Finally then Harmeny School registered in April 2002 and remains active as a school care accommodation service?

A. Yes.

Q. Then you say that you have reviewed fitness-to-practise referrals as at 30 January to identify those related to abuse of children and young people and you took into account physical, sexual and verbal abuse, boundaries and inappropriate restraint?

A. Yes.

Q. Again, I think you have given evidence previously as to why you've taken into account boundaries, but perhaps just in the context of this case study, can you tell us why you looked at boundaries and what's meant by that?

A. Yes. I think boundaries -- I'm not -- trying to recall if there were any cases that related to boundaries in relation to this. Yeah, there was one relating to boundaries.

I think generally one of the concerns that we might have, particularly with children or young people workers might be to do with boundaries in terms of grooming-type behaviour, would be an example of that. So we had a very recent case not related to this part of the

sector, but one that I saw, just very recently a decision was made in which a children and young people's worker had been sending messages to a young person and said to that young person, 'Would you like to meet, but don't tell anybody, don't tell any other workers that I'm sending these messages'. So really things that are potentially crossing a line between that building a relationship with an individual, as is required by The Promise and we'd want to see from staff, versus stepping over what is an appropriate boundary and potentially stepping into that territory of grooming behaviour.

Another example might be buying gifts for an individual that's inappropriate and those kinds of behaviours. We wanted to make sure we were covering those sorts of behaviours and anything that might be relevant for the Inquiry.

Q. If we look on over the page, please, at the top of the page, paragraph 31, you note that you excluded referrals in relation to practice issues such as medication, speeding or failure to follow procedures and you have excluded behaviours outside of work, unless that related to abuse of young people?

A. Yes.

Q. If we can move to page 12, please, you give us a list

there and we'll look at some of these in more detail.

Could I ask you, please, to look at the penultimate entry, which is 13 January 2016, was the referral date. That's a worker at Starley Hall School. It says that the summary of this is that this person failed to adhere to safety plans and allowed contact with family members without authorisation.

Why did you think that this would be relevant to the Inquiry's work?

A. (Pause)

Apologies, I think that should not have been included. I think I've been overzealous with what I've included for risk of missing something that might have been appropriate, but you are right, that doesn't fall within any of the categories, so that should not have been included.

Q. Okay, thank you.

We're going to look at some of the information that you've given us in a bit more detail in a moment, but just so that we don't have to come back to this report again. If we can look, please, at page 13, it notes there: 'Referrals currently being investigated'.

You note a referral made in May last year in respect of a worker at Harmeny, where there is an allegation of financial abuse of a young person. You say that the

referral source was a previous employer?

A. Yes.

Q. Is that still ongoing, do you know?

A. I believe it's still ongoing, I'll check that.

Q. Then the second entry is a referral dated 11 December of last year, the organisation is Seamab and the description is an allegation of inappropriate touching of a young person and the referral source was a colleague?

A. Yes.

Q. I assume that's still ongoing?

A. Yes.

Q. Can I ask you, please, to look -- it will come up on the screen, to look at SSC-000000085.

If we scroll down a little please, if we go down to the misconduct, perhaps this might help orientate ourselves.

The misconduct, it says it was on 15 March 2013, it was in respect of somebody employed as a residential childcare worker at Harmeny.

The first issue is that during the course of this person's employment, they failed to adhere to the school's recording policy on physical intervention by not completing the physical intervention report following a physical intervention with a service user.

Then on another date, 17 April 2013, the person acted in an inappropriate manner towards a service user aged 9 in that, it says:

'You took him to an inappropriate location, namely the utility room, opened the external door and exposed him to cold conditions while [the child] was dressed only in pyjamas, and held him there by his hand.'

Then secondly:

'You had [the child] sit on a mat at the area beside the front door and held him there, despite him expressing he was uncomfortable [going over the page] and scared that staff would come through the front door and in doing so, you put [the child] at risk of harm.'

If we go back to the first page again, please, we see that it says the council decided that this person had committed misconduct and the decision was to impose a warning on the worker's registration for a period of 12 months?

A. Yes.

Q. The decision, I think you note in the summary, is that this was an officer decision?

A. Yes.

Q. What do you mean by that?

A. Yes, there are two ways that we can impose sanctions at the SSSC. The first is an officer sanction and the

second is a decision made by a Fitness to Practise Panel at a hearing.

We investigate all of our cases internally within the SSSC and when the investigations conclude and we reach a decision, that's based on the evidence that we have and we conclude which sanction we think is appropriate in all of the circumstances, based on the evidence.

At that point, we write out to the individual worker concerned to tell them we've concluded our investigation, what we have concluded. We send them the evidence that we're relying upon and we tell them what we intend to do. So, for example, we would say, 'We intend to impose a 12-month warning on your registration, unless you opt in for a hearing'. If somebody does not opt in to a hearing, that sanction would be imposed.

The alternative is that somebody does opt into a hearing and then a hearing takes place, hears the full evidence and makes their own decision on the basis of all of that.

Now, that happened. This change to opting in for hearings happened in 2021, so at the point that this decision was made, which I think was 2013 or 2014, that was prior to the opt-in process starting, so at that

stage we operated a consent model.

So it was the same process, that we would write to the individual worker to say: 'Here is the decision we have reached, if you would like to consent to that, you need to sign here and tell us, otherwise we'll arrange a hearing.'

So previously hearings were by default and now they're not. So at the point that this decision was made, this individual must have consented to that warning in order for that to have been imposed. So it was made officer decision with no consideration of evidence by an independent panel.

Q. The decision obviously sets out the relevant parts of the code of practice and why this was considered to be misconduct.

But if we go on to page 3, at the bottom of the page we see the reasons for the sanction and the factors of concern are noted to include that there is more than one incident of misconduct, there was potential of physical and emotional harm to the child and then, going over the page, there's evidence that the child was worried during the period that he was on the mat, so he may have suffered emotional harm, albeit there is no evidence of lasting harm and, finally, these offences were committed at work.

Why would the fact that these offences were committed at work be noted as a factor?

A. Generally we would consider that to be an aggravating factor. We consider behaviour that takes place outwith work, often that's entirely relevant to do so and we would take action in those cases, but we would consider it more serious generally if something takes place involving service users within a workplace than if it takes place outwith work.

Q. Then if we look at, 'Factors in your favour', it says that:

'The council is satisfied that you were trying to act in the best interests of the child throughout the incident.'

What would that be based on?

A. That statement would have been based on information provided by either the worker or the employer, so would have been perhaps in the form of a personal statement from the worker explaining the circumstances. It may have been as a result of an employer investigation, but that sounds as though it's something that's come from the worker to explain why they had behaved in that particular way.

Q. Then it refers to the most recent incident being -- both incidents, I think, were in April 2013 and then it notes

that this person had continued to work with the employer and they had provided extremely positive references and there had been 'no further concerns with your practice', so that would be a factor in the person's favour as it states?

A. Yes, again potentially -- all of the factors have to be weighed up against each other and some would carry more weight than others, but, yes, if somebody -- the longer somebody has continued to work without any further incident would be a stronger mitigating factor.

Q. Then the next bullet point is that this person co-operated with the investigation by providing comments?

A. Yes.

Q. Then the next bullet point is that the person had demonstrated insight in that they had acknowledged that on reflection they should not have done what they did, while they explained their reasons for doing so at the time, and they also stated that they understood it was their responsibility to complete physical intervention report forms and the importance of this.

Why would these be important factors?

A. Insight, and regret and remorse are all factors that would form again part of that balancing act when making a decision. So if somebody has shown insight as to why

they should not have behaved in the way that they did, if they've been able to demonstrate that they understand that and give a level of reassurance that that would not re-occur, then that would be something that the decision-maker would take into account, that level of satisfaction as to: is this person a risk? Do we believe they're going to behave in the same way in future? And if not, then that would be a mitigating factor, potentially, again, depending on the specific incident and severity of it, but in this case, if it wasn't a long-standing pattern of behaviour if somebody has acted in a particular way, has fully demonstrated that they understand that and why they would not behave in that way again, that would generally be a mitigating factor in the circumstances.

Q. Then we see that the sanction imposed was the 12-month warning on the record?

A. Yes.

Q. If we can move on to another document now, please. SSC-000000086.

Now, if we look into the first paragraph, we can see that this is notice of a decision of the conduct subcommittee, which met on various dates, ending 23 April 2015, to consider an application by the council that the registrant be removed from the register.

This would suggest that this is a case in which a hearing took place?

A. Yes.

Q. And that the SSSC's position was that the registrant should be removed?

A. Yes.

Q. In every case where there's a hearing, does the SSSC suggest to the panel what the outcome should be?

A. Yes, on very rare occasions on an application hearing it may be that there is no recommendation made if somebody was applying to be registered, it would be very, very rare that that might happen, but in a case where somebody is registered, there would always be a notice of decision drafted setting out what it was that the SSSC thought the sanction should be, based on the information provided.

Q. In this case, the decision of the subcommittee was to warn the registrant and place the warning on the registration for a period of three years?

A. Yes.

Q. So the subcommittee didn't agree with the position adopted by the council?

A. Yes. What can happen is when evidence is heard on the day, it does not necessarily accord with the written evidence that has been provided or perhaps there's

an additional witness that comes along and -- not specific to this case, but more generally there might be additional circumstances. So, yes, the panel would make their findings based on the evidence that they have heard and read, and it may well be the case -- it is sometimes the case -- that different decisions are imposed than have been sought by the SSSC.

Q. Then we see the charge at the bottom part of this page. The charge against this person was that on 18 January 2014, when employed as a care worker by Seamab, this person held a 9-year-old child, I think under his arms, it says 'by his arms', but it's amended over the page, so just reading that just now, under his arms, together with this person's colleague, who held the child by his legs over a bath containing water and then (b):

'Together with your colleague, lower the child fully clothed into a bath containing water.'

Then the charge goes on that:

'In doing so, you breached your employer's code of conduct and did cause or were likely to cause the child physical and emotional harm.'

A. Yes.

Q. That was the charge and if we go on to the next page just for completeness, at the top of the page we see the

amendment of the charge that I've just mentioned.

Then if we look into the findings in fact, we can see that this registrant, at paragraph 1, had been on the register since 17 September 2009, that they had an SVQ qualification, Level 3, and an HNC in social care. In the next paragraph, that they had worked at Seamab since 25 February 2002, initially as a sessional wakened night care worker before becoming a residential care worker, and she was in the post of residential care worker until 10 March 2014, come back to that.

So at the time of the incident she was employed as a residential care worker?

A. Yes.

Q. Then the committee found in fact that the registrant did hold the child under his arms over the bath and did put the child into the bath and that the child was 9. Then at paragraph 8 we see that the child had been resident within Seamab since 2014.

So [redacted] before --

A. Yes.

Q. -- the incident. At paragraph 9, it's noted the registrant didn't know the child well and she hadn't spent a significant amount of time with the child.

Then at paragraph 10, they also found in fact that the child was a very vulnerable service user who had

been upset for a period of some hours before the incident. Whilst he appeared to have calmed down prior to the incident, he had been calm for a relatively short period of time.

At 11 they found in fact that, although she didn't know him well, she had witnessed his volatile behaviour and was aware of his vulnerability.

Then if we go on over the page, it's noted that she didn't carry out any kind of risk assessment of the potential emotional impact on the child of what she did.

At paragraph 13, it notes that the subcommittee was unable to conclude whether the child was content to be placed fully clothed in a bath containing water, but they were satisfied that the child wasn't physically harmed. They do note that there's obviously an inherent risk in the conduct.

A. Yes.

Q. Then at paragraph 14, they refer to the upset of the child and that the child continued to question the actions for a period of time after the incident?

A. Yes.

Q. Then we can see at paragraph 15 that the registrant was suspended by Seamab on 18 January, so immediately after the incident?

A. Yes.

Q. And she was dismissed by Seamab on 10 March?
A. Yes.
Q. If we go down the page, we see that the finding was that misconduct had taken place?
A. Yes.
Q. They go on to give their reasons for that and then at the bottom of paragraph 4, they note that the sanction was -- sorry, page 4, the last section, the decision was that they would place a warning on the register for three years and if we go on over the page, we see the reasons for that.

Paragraph 1 they describe it as a relatively serious error of judgment, but they were satisfied that there were no particular aggravating factors in the case.

You mentioned being at work is an aggravating factor?
A. Generally, yes, that would be considered to be an aggravating factor, if it was behaviour carried out within the scope of work, which this decision was made when it was -- we have decisions guidance in place for all decision-makers, which is about to be reviewed and relaunched, I think this month or next, but it was two previous versions that was in place at the time that this decision was made. It was an indicative sanctions guidance, I think, at that stage, but from memory

I'm sure that would have had the same factor in relation to something happening within the workplace being more significant.

Q. Then the mitigating factors include at paragraph 2, co-operation throughout and an early admission of the facts and that she had accepted her actions were inappropriate.

A. Yes.

Q. She'd expressed regret and had apologised for her actions at paragraph 5. She had a long career in residential childcare with no previous history of wrongdoing and had produced references in support of her good character and practice. Would these be mitigating factors normally taken into account?

A. Normally taken into account -- again, part of the balancing act and depending on the seriousness of the behaviour, some may carry more weight than others, also balanced against public interest, so, yes, lots of competing factors but generally those would be part of the consideration in terms of mitigating factors.

Q. If she admitted her conduct, what would the hearing have been about, because there seemed to be a hearing that lasted a number of days?

A. I think they made findings in fact, so it would depend at what stage -- which of the facts she accepted. It

may well be sometimes that if -- people will accept behaviour but they might not accept all of the findings in facts. The way that we run our hearings is that we don't get into the business of sort of negotiating allegations in advance. It's a case of allegations are there to be proved and if they're not accepted, we'll lead evidence in respect of those in their entirety.

MS INNES: My Lady, I'm conscious of the time and I'm finished with this document.

LADY SMITH: I think we should take a morning break at this stage. Would that work for you, Hannah?

A. Yes, thank you.

LADY SMITH: Let's do that.

(11.30 am)

(A short break)

(11.45 am)

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

A. Yes, thank you.

MS INNES: If we can look please at SSC-000000087 and just so that you can see what this is about, if we go down to the charge, we can see there that the charge against this worker is that on 18 January 2014, when employed as a sessional worker by Seamab, this person lifted a 9-year-old child over her shoulder and carried him to

a bathroom using a fireman's lift and then at (b):

'... held the service user by his legs together with your colleague, who held the child by his arms over a bath containing water and tell the child that you were going to drop him into the bath.'

And then at (c):

'... together with your colleague, lower the child fully clothed into a bath containing water.'

This is the same incident that we looked at before the break, but it's the other worker involved in the incident?

A. Exactly, yes.

Q. I think that we can see the differences, I suppose, are that this person lifted the child over her shoulder and carried him to the bathroom?

A. Yes.

Q. So that was her that did that, not her colleague?

A. Yes.

Q. Then also telling the child that she was going to drop him into the bath?

A. Yes.

Q. If we look up to the top of the page, it says here that there was a hearing on various dates in March and is it your understanding that this hearing was separate from the hearing that we've just looked at in relation to the

colleague?

A. Yes, it took place, I think, within a different location and on different dates and I assume with a different panel, judging on the style of the notices, I imagine a different panel.

Q. Given that it was the same incident, why would the hearings have been held separately?

A. There is provision in our rules that we would now use, I think, generally in a case like this, we would tend to have a conjoined hearing where we would hear all of the evidence together. It may well be that if facts had been admitted in advance and there was no need to hear evidence on facts, that then they would be held separately, but if there was factual evidence to be heard, we would try to hold that as one hearing.

I think there were a lot of facts that seemed to have been agreed, clearly in the second notice it's set out what the agreed facts are, so it may well be that because there was such an agreed statement of facts, that there wasn't the same level of evidence to be led, so they held -- there were separate hearings.

Q. We see, I think, that the decision of this subcommittee in relation to this registrant was that it was misconduct and a removal order was imposed?

A. Yes, that's correct.

Q. Then if we go on over the page, to page 2, we see at the top of the page that the convener recused himself because he'd previously been concerned with the case and the hearing went ahead with the CSC, the conduct subcommittee, comprising a due regard member and a lay person, to which both parties had indicated they had no objection.

Can you explain what is going on there in terms of who remained on the committee?

A. In terms of our rules, a panel member should not sit on a hearing if they have been involved in a previous hearing in relation to that individual. For example, if there had been an interim order, a temporary order hearing, any of the panel members who sat on that temporary order hearing would not then be permitted to sit on the final substantive hearing. So I would suggest it would be something related to that.

This was again under our previous proceedings. We now have legally qualified chairs. At the point at which this decision took place, we had not brought in legally qualified chairs, so we had a legal adviser who advised the panel separately and a lay chair, so it would have been a lay chair who recused themselves in the circumstances.

LADY SMITH: I did wonder when I saw this, Hannah, whether

it was that the person who had previously been involved was involved with the case of the person who ended up getting a warning.

A. Yes.

LADY SMITH: But it's not that, it's the same case?

A. I don't think so. I think the dates of the hearing for the warning came after the dates of this first hearing. I think this hearing was March and I think the warning was April, so yes, I think it's more likely to have been an interim order hearing, a temporary order hearing.

LADY SMITH: Right. Could that ever happen, that you have got two people involved in an incident so there are going to be two different cases and a person who is on the panel for the first employee is also on the panel for the second employee, put on that panel, and then it's later realised they shouldn't be there because they heard from the other person about the incident?

A. Yeah, we would -- normally we -- we've got lots of checks and balances in place behind the scenes to make sure that we're quite clear on who should and who should not be appointed in certain hearings if they've sat in previous hearings, what involvement they have had, if there's been discussion with previous members then something like that, we might not be aware of, if they hadn't been directly involved, but we ask members, when

we send out the paperwork to them, to give that close and quick consideration and if they're aware of any of the parties and shouldn't be sitting on it, to let us know as quickly as possible.

It would be very unusual for somebody to get to a hearing and then become aware at that stage that they would not be able to sit on the hearing. And indeed, I'm sure in terms of our current rules, our 2021 rules, we wouldn't be able to proceed or we certainly wouldn't be able to proceed without a legally qualified chair, so we wouldn't be able to proceed with two panel members. This was under a previous iteration of the rules.

LADY SMITH: It would feel wrong if somebody who had heard the evidence in relation to one person involved in the incident and been involved in the decision-making there, was also on the panel in a fresh case in relation to somebody else. They may not realise until quite late in the day that they were hearing about the same incident, I appreciate that, but do your processes involve warning members that they really have got to rack their brains about there being any possibility of prior knowledge of the people or the events?

A. Yes, that's the system that we have. I think probably what I think we're a lot better at now than perhaps we were then was us doing more practically about that

ourselves, so we would have a very clear sense of who have sat on which hearings. We don't have a huge number of hearings. We have about 150 a year, so it's not a huge number of hearings, it's a very small team that administer those, so they have very clear knowledge so they should be well aware of those circumstances to try to avoid them. But, yes, we're clear with members to make sure to avoid any conflict of interest that might come up.

And if it was -- we were looking to consider two cases, we would be looking to conjoin them and have it as one hearing, if that was what was deemed to be important.

LADY SMITH: Because, of course, what occurs to me, looking at it from the point of view of child protection, is that if you did have the cross-over of panel member on case number one also turning up as panel member on case number two and it not being addressed at the time, that sets up an appeal point and it may take some time for the appeal to be disposed of, during which, depending on the employer's approach, the person may still be working with children?

A. Yes. Absolutely. That's entirely correct. The one measure that we would put in place, we would always seek if it was a panel imposing an order, a removal order.

We would at that stage also seek a temporary suspension order to take us beyond the period of appeal so that should an appeal be lodged, the removal order would not stand so it would be suspended in any event --

LADY SMITH: But if it wasn't a removal order.

A. Yes, there would be no such protection exactly.

LADY SMITH: And it was a warning order --

A. Yes, there would be nothing in place, exactly.

LADY SMITH: Person's back at work?

A. Yes.

LADY SMITH: That's a very long way of saying, Hannah, it occurs to me that it's really critical that panel members understand their responsibilities in relation to thinking the unthinkable. It may be very easy for them to assume the SSSC will always get this right, 'They won't put me on a panel that I shouldn't be on'.

Well, that could happen.

A. Yes, it could. I'm relatively confident in our processes, but I will revisit them to make sure that we are as robust as I think we need to be.

LADY SMITH: This is a very good example to use as a teaching example and hypothesise about what could have happened if that problem hadn't been picked up at that stage.

A. Yes. Thank you.

LADY SMITH: Thank you.

MS INNES: Thank you, my Lady.

You mentioned a moment ago that there were agreed facts and we see in this decision that there were agreed and admitted facts and then facts that were found, so they're broken down in this decision.

On the page that we're looking at, we can see under the agreed facts that this registrant had been on the register initially from 26 March 2009. If we look down to point 3, she had an HNC and an SVQ3 in health and social care in children and young people. She had commenced employment with Seamab on 1 November 2007, initially as a residential care worker and then from October 2011 as a sessional worker. That's the role that she was in at the time of the incident.

A. Yes.

Q. If we go down to points 8 and 9, we can see that this worker was also suspended by Seamab on 18 January 2014 and then was dismissed by Seamab on 8 February of the same year?

A. Yes.

Q. If we go on over the page, we see the admitted facts and the registrant admitted some of the facts that we've seen, so that she carried the child over her shoulder, that she held him by the legs, together with her

colleague, and that she lowered the child fully clothed into a bath containing water.

From what we saw in the charge, the part about whether she told him what she was going to do or not, was not admitted?

A. Yes.

Q. Then we've got findings in fact, which are at paragraph 2. It notes that the child is a very vulnerable service user with complex needs.

At paragraph 3, it notes that in addition to the HNC mentioned, the registrant was given additional training from Seamab on understanding and dealing with challenging behaviour.

Then at paragraph 5, it notes that at the start of her shift, the registrant was given a brief handover by a colleague with very limited information about the child.

At paragraph 7, her first ever contact with the child was later in her shift on 18 January 2014?

A. Yes.

Q. So that was the first time that she had seen him?

A. Yes.

Q. Then it refers to the child's behaviour becoming challenging at paragraph 8.

If we go on over the page, at paragraph 11 there was

a finding in fact that the lift was a fireman's lift as described in the charge, so I think that wasn't admitted, but it was a finding of fact?

A. Yes.

Q. Then there's reference to the colleague having filled a bath and the registrant not being aware of the temperature of the bath or testing it and then, at paragraph 15, we see that after holding the child over the bath, it was found in fact that she told the child that she was going to put him in the bath. So that was part of the charge as well?

A. Yes, it was.

Q. Then it talks about what happened after the child came out of the bath at paragraph 18. It says that the colleague asked the child to take off his wet clothes and put on his pyjamas. His mood changed and he began crying and said he did not want to do so and he wanted to go to his room.

Then, at paragraph 19, there was evidence from another worker, I think, saying that she didn't agree with the actions taken?

A. Yes.

Q. If we move on down the page, we can see further findings in fact about the reaction of the child.

If we see at paragraph 23, this also tells us that

it was reported to the on-call senior at Seamab, they made a child protection referral to the placing authority, there was a joint police and social work investigation and there were no criminal proceedings?

A. Yes.

Q. That tells us a bit more than the previous decision about the reaction of Seamab?

A. Yes.

Q. Then if we move on to the top of page 5, we see that [redacted] following the incident, the child was removed from Seamab by the placing authority and returned to the care of his mother, but he was then subsequently returned to Seamab?

A. Yes.

Q. If we look down below, we see that misconduct was found and a removal order was made. If we look down, there's a sentence:

'The subcommittee accepted the advice of the legal adviser.'

Is this essentially saying they accepted the advice in relation to sanction or something else?

A. That would be the legal advice that was given, I would have thought throughout the hearing, so with regard to maybe the relevant legal tests or any case law if that had been referred to. There's no mention of case law

there, but, yeah, normally the legal tests as are appropriate.

LADY SMITH: I suppose it might cover which paragraphs of the code were relevant, and I see there is something like 11 of them quoted there?

A. It might do, yes.

MS INNES: If we look at paragraph 1, we see that the subcommittee took into account that the registrant had no previous record with the council. However, they note a number of aggravating factors. They say the misconduct was very serious, it involved a disregard for the wellbeing of a vulnerable service user, it was an abuse of trust. The registrant has shown insufficient insight or regret. There is a risk of harm to members of the public if the behaviour is repeated. The behaviour took place at work. The behaviour falls well below the standard expected. It constitutes a serious disregard of the code and no testimonials were produced.

A. Yes.

Q. This subcommittee appear to have taken all of these factors into account --

A. Yes.

Q. -- as aggravating factors?

A. Yes.

Q. Then if we go over the page, it tells us, at paragraph 3, that they started with the least restrictive sanction and worked upwards.

At paragraph 4, they say a warning is not appropriate or sufficient, it wouldn't adequately protect members of the public interest. It wouldn't recognise the serious nature of the misconduct or address the behaviour. The registrant has not demonstrated sufficient insight into her actions. There was no expression of regret or apology.

A. Yes.

Q. Although she had admitted what had happened, the subcommittee seems to be indicating here that there was still a lack of insight?

A. Yes, I would take from that there was no expression of regret or apology, that, yes, perhaps she had admitted some of the facts or the circumstances but wasn't going to the degree that was required by the panel.

Q. Then at paragraph 5, they looked at the possibility of conditions with or without a warning and their conclusion was that they weren't workable or enforceable and they note again insufficient insight or regret and they say:

'She is understood not to be in the employment which requires registration with the council.'

Therefore there couldn't be any conditions imposed.

Would that seem to make sense that if she's not continuing to work, the council can't impose or enforce any conditions?

A. Yeah, no condition would be enforceable. What would happen if conditions were opposed, that would be the final sanction. If the worker was not working at that point in a registrable role, at the point the decision was made, she would not be eligible for registration and would then be removed and the conditions would then have no effect. If, in future, she reapplied for registration, there would be a flag on her file and those conditions at that stage would be reconsidered if they should be reapplied to her registration.

Q. At paragraph 7, we see that a removal order was considered to be the only appropriate sanction.

We have seen two decisions about the two workers involved in the same incident; one got a warning and one was removed from the register. On the face of it, that might seem to be inconsistent?

A. On the face of it, yes. It would be unusual, but not unheard of, because every case is fact specific and part of the really important picture is that point about remorse and regret and the risk of the behaviour being repeated. So all of that is an important part of that

consideration. Far from the only one, but that is part of it, so we do see on occasions different sanctions being imposed for the same behaviour.

LADY SMITH: I suppose you could summarise that as the panel looking to see what the person's attitude is on reflection?

A. Exactly.

LADY SMITH: If the registered employee had reflected, which is the starting point that you need to begin being reassured about the possibility of them not behaving in this way in the future?

A. Yes. I think if a panel are able to hear from an individual as part of that hearing, if they're there to give evidence and to explain what they've learnt or what they would do differently, that can be a really important part of the process if they can satisfy the panel as to that. Not always enough, but it can make the difference between a higher sanction and a lower sanction.

LADY SMITH: It also looks as though this individual was the prime mover, if you like --

A. It looks to be that way, yes.

LADY SMITH: -- in the whole incident that ended up with the child being put into the bath fully clothed?

A. Yes, yes.

MS INNES: I'm going to move on to another decision now. It's SSC-000000088. This is a notice of decision, I think this is an officer decision. Again, just to orientate you as to which one this is, if you look towards the bottom of this page under misconduct, you can see that this person was a care worker at Starley Hall School. The misconduct is that during the course of this person's employment on 13 May 2013, they used inappropriate language towards a service user, in that they told a child to 'stop behaving like a dick' or words to that effect.

Then on 16 May 2013, there was an issue in relation to giving the service user money and there being a risk that the young person would use that to abscond.

A. Yes.

Q. There are two factors here?

A. Yes.

Q. If we look back up the page, we can see that it was considered that this was misconduct and that the sanction was an imposition of a warning for a period of two years and three months?

A. Yes.

Q. Again, because this is an officer decision, it appears that this was essentially accepted by the registrant?

A. Yes, at this point in time, the registrant would have

had to sign an acceptance, a consent to the order being imposed.

Q. If we look on to page 3 and the bottom of the page, in relation to reasons for sanction, again at 'Factors of concern', two incidents:

'Secondly, swearing at a service user and speaking to him in a derogatory manner may have caused emotional and psychological harm to the young person. If the service user had absconded [that's going on to the issue of the money, I think] he would have placed himself at risk of physical and emotional harm.'

Then again a factor of concern was it was essentially while this person was at work?

A. Yes.

Q. Then the factors in favour included that there had been no subsequent incidents, co-operation with the investigation and insight shown and regret expressed?

A. Yes.

Q. Then if we go on over the page, a previous good history with the employer, no direct harm to service users.

Then, at the penultimate bullet point, it says that there was supervision every four weeks with the employer as part of the disciplinary outcome, so it looks as though the employer had imposed some supervision?

A. Yes.

Q. There did not appear to be a real risk of repetition of the behaviour?
A. No, exactly.
Q. These are all mitigatory factors?
A. Yes.
Q. You have given us a couple of other decisions in relation to workers at Starley Hall, both of which are after December 2014.
A. Yes.
Q. If we can look at these for completeness, please.
First of all, SSC-000000090.
LADY SMITH: Is this the one that's fourth on the list in the table?
MS INNES: I'm afraid I don't have the table.
LADY SMITH: Oh, you don't have the table in front of you. Don't worry, I'll pick that up.
MS INNES: The date the notice comes into effect is 13 September 2018. So it's on the screen now.
LADY SMITH: Thank you. I've found which one it will be.
MS INNES: This is a notice of a decision and so again it's an officer decision.
A. Yes.
Q. If we look down to the findings in fact, we can see that this was an incident around 3 June 2017?
A. Yes.

Q. The registrant was employed as a residential childcare worker at Starley Hall?
A. Yes.
Q. There's first of all reference to a failure to act in accordance with the young person's risk assessment, when that person's behaviour was escalating, so failed to direct the young person to take time out to calm down and failed to walk away from him?
A. Yes.
Q. Then, secondly, the issue was that there was an attempt to restrain, which included holding the child's door closed to prevent him from leaving the room.

Next paragraph, over the page, screaming at him to get back in his room, putting his arm around his neck into a headlock, taking a hold of the young person's hand and use it to hit the young person three times. So using the young person's hand to hit themselves and cover the young person's face with a throw?
A. Yes.
Q. It notes that this caused distress and the registrant left their shift early after this incident?
A. Yes.
Q. If we go back to the first page, again in terms of the notice of decision, we can see that there was a finding that fitness to practise was impaired and a removal

order was made.

Why does it say 'fitness to practise was impaired' as opposed to 'misconduct'?

A. Yes, we moved to a fitness-to-practise model in 2017, so the previous notices that we've looked at that pre-dated that were under the misconduct model and it was not a fitness-to-practise model. So now we have a three-stage process for impairment hearings.

We consider the facts first of all.

The next stage is to consider whether or not those facts amount to somebody's fitness to practise being impaired.

If they do, whether a sanction is appropriate in the circumstances.

Q. Then if we go on to page 4, where we see the reasons for the sanction, under 'Factors of concern': no demonstration of insight, a failure to demonstrate an understanding of the risk of harm, the fact that the worker was experienced, that the behaviour took place inside of work, that it presented a significant risk of harm to the young person and represented an abuse of trust?

A. Yes.

Q. Then in terms of factors in the person's favour, it says as far as the SSSC is aware, the behaviour was isolated?

A. Yes.
Q. That's the only factors in favour of this person?
A. Yes.
Q. And they were removed from the register?
A. Yes.
Q. Finally, in terms of the decisions, if we can look please at SSC-000000089, this was a decision, if we look down to under 'Decision', it says this is a notice of decision made by the Fitness to Practise Panel. So this was a decision made by a panel after a hearing?
A. Exactly.
Q. The panel decided that the allegations were proved and they imposed a removal order?
A. Yes.
Q. If we go on, over the page, under 'Proceeding in absence'. Preliminary matters, proceeding in absence, this registrant was neither present nor represented at the hearing?
A. Yes.
Q. I think ultimately the panel decided to go ahead in the absence of this person?
A. Yes.
Q. If we look on to the findings in fact, on page 3, at the bottom of page 3, this person had been registered on 3 May 2019 and was employed at Starley Hall School on

5 August 2019.

Then if we go on over the page, it then goes on to explain, I think, that during the course of employment, when supporting a young person at an activity in the community, this worker had taken an unknown substance --

A. Yes.

Q. -- and had also spoken about taking ketamine and being incapable of caring for a young person?

A. Yes.

Q. Ultimately, as we've seen, this person was removed from the register and there was a finding that fitness to practise was impaired?

A. Yes.

Q. I'm going to stop looking at documents now and just ask you about a couple of matters, which I think you've been able to check in the intervening time.

A. Yes.

Q. First of all, has the standard in respect of foster care been implemented or not?

A. It has not. But what I am in a position to share is that Scottish Government consulted last year, I think maybe into this year, on the future for foster care was the consultation and the current programme for Scottish Government states that a Children and Young Person Care Bill will be brought forward ahead of the summer recess,

which will be informed by that consultation on foster care. So the standard of foster care may be part of that. I'm not sure of that part, but there has been progression made by Scottish Government in relation to foster care.

Q. I understand that you may have something to add in relation to the issues in respect of the interaction of the SSSC with Disclosure Scotland?

A. Yes, and apologies I did not have this when we spoke about this earlier. But we had spoken about the fact that Disclosure Scotland are not able to provide us with a level of information and that we had been told previously we were unable to publish information with regard to any decisions around listing.

The PVG Act, I believe section 66 covers that. I think my understanding is we were advised that to disclose that somebody -- the Act prevents you from disclosing that somebody is listed, so for us to publish information about a listing would indeed confirm the fact that somebody had been listed, so we're prevented from doing that.

LADY SMITH: Is the theory that if somebody wants to find out if a person is listed, they have to go directly to Disclosure Scotland and --

A. Yes.

LADY SMITH: -- be in a position where the application is justified and appropriate?

A. Yes, that's my understanding. The legislation prevents us from making that information public.

Again, understanding from my organisation, from conversations going back to that time, was that there perhaps had been a concern about somebody's identity being made public in relation to something to do with children and young people and then action being taken against them, if that was public, by unrelated parties to the behaviours. But I'm not sure. That was just conversation.

LADY SMITH: I wonder if it's simply an approach to data protection responsibilities.

A. I suspect so, yes.

MS INNES: I think that covers the additional matters that you wanted to address.

A. It does, thank you.

MS INNES: I have no further questions for you, Hannah.

A. Thank you.

LADY SMITH: Nor do I, Hannah.

Thank you so much for bearing with us. It's been a long morning, but we've managed to cover a lot of ground thanks to the preparation you've done and the care you've taken over helping us. I'm really grateful

to you and now I'm able to let you go and get back to whatever the afternoon holds for you. I just hope it's a bit less stressful than this morning.

A. Thank you.

(The witness withdrew)

LADY SMITH: Ms Innes.

MS INNES: My Lady, we do have a read-in which could be done before the lunch break.

LADY SMITH: Let's go for it then.

MS INNES: Thank you.

Ms McMillan will deal with it.

LADY SMITH: Thank you.

I'm guessing this is either 'Kevin' or 'Martin', but I'm not sure which.

MS MCMILLAN: It's 'Martin', my Lady.

LADY SMITH: Thank you.

'Martin' (read)

MS MCMILLAN: This is the statement of an applicant who is anonymous, as your Lady has identified he will be known as 'Martin'.

The reference for 'Martin's' statement is WIT-1-000000610.

In his statement, he says he was admitted to the Royal Scottish National Hospital when he was 3 years old and left when he was 9 years old.

Records show, however, that he was admitted in [redacted] 1962 and discharged in [redacted] 1966.

LADY SMITH: Thank you.

MS MCMILLAN: He was admitted to Ladysbridge Hospital, Banff in [redacted] 1966, where he remained until he was an adult. He was discharged from there in [redacted] 1988, aged 36.

'Martin' composed several letters in which he reported abuse at both the Royal Scottish National Hospital and at Ladysbridge. These letters can be found in the bundle under the reference ABN-000003968 and they appear to be dated between November 2008 and April 2013.

'Martin' was born in 1952 [redacted] in Aberdeen.

From paragraph 3, 'Martin' tells us about how he was placed within the Royal Scottish National Hospital and his time there. He says:

'When I was born, the doctor at the hospital told my mum and dad I had a bad illness in the body and a disability, so I was sent to the Royal Scottish National Institution in Larbert. I was supposed to be getting help there. The doctors told my mum and dad they would be helping me all the time.

'When I first went to the Royal Scottish National Institution, I was in the baby ward. I was 3 years old.

I stayed there until I was 9 years old. My mum and dad took me there and back home on the train. Two female staff took me down a big corridor to Block One, the old man's block. There were no other children in that ward. When you went in the front door, the staff locked the door behind you. You couldn't get in and out.

'There were two or three hundred patients in five blocks. Each block had three bedrooms. Block One was the old man's ward, Block Two was half and half, with kids. The children were in Block Three. Block Four was a babies' ward, Block Five was for people who could only go out and about in their wheelchairs. Those people were not allowed to go out in the grounds. The children didn't mix with the women. You weren't allowed to.

'Later they built new blocks across the female wards. In the new blocks, there were four bedrooms in each block. In the women's ward there were nine or ten women in each bedroom. There was a babies' ward with 30 babies and about 40 children, who were 9 to 12 years old.

'There were big grounds with a high fence around them and two big metal gates. The gates were meant to be closed at night but sometimes they weren't closed. You weren't allowed to play in the grounds. There was a big dining hall that three of the blocks used. You

were only allowed to go to the shop and the gym. The shop was in the same corridor as the dining room. You were given tokens to spend. You had to be escorted to the shop and gym by two staff members.

'There was an emergency button you could press on the ground floor. There had been some arson with fires happening. Two or three of the old men smoked in their bed and their beds went on fire. You weren't allowed to smoke in the ward. You had to go outside with a member of staff.

'When I was in the old man's ward there were only two staff. I don't remember their names. One of them, a man, was the boss and told the other staff member and the patients what to do. I don't think the staff were trained enough. Dr Brown was the doctor in charge.

'My earliest memory from the Royal Scottish National Institution is the day I was sexually assaulted by a patient. I had moved to the male block by then. I was 3 years old. The other people in the block were a lot older than I was.

'I was in a ward at the top of the building in the attic. I slept in the same ward as men much older than me. Some were 60 to 70 years old. There were ten or 15 beds in the room. You all had to be in bed by 8.00 pm. You weren't allowed to stay up. You were locked in the

ward at night. There was a toilet in the ward by your bed. There was no TV in the ward. All the patients were given a Largactil tablet at night. It made you sleepy. There were no staff on at night.

'You were up at 6.00 am every morning. You were straight to the bathroom to get washed and then through to the dining room. You went to the school and back to the ward. The school was inside the hospital. You weren't allowed to play with anybody. You didn't have to do any chores.

'Some wards didn't have toilets and folk would do the toilet on their bed. In my ward, three or four people wet the bed. The staff weren't happy with them wetting the bed and got very angry, because they had to change the beds.

'I wouldn't say the food was great. The food you were getting wasn't really cooked right or good quality. You couldn't say anything to the staff about the food. If you refused to eat the food, the staff would force you to eat it. The staff forced your mouth open and put the food into your mouth on a spoon and held your mouth closed until you swallowed it.

'The cooks worked in the kitchen off the big dining hall. You had breakfast, dinner and supper. You were marched going for your meal. You had to stand in a long

queue for your meal. By the time you got served there was hardly anything left. After the meal was finished, everyone in the dining room had to get up off their chair and stand in a row, then walk in a line back to each ward.

'The bathroom had two baths. There were no showers. You saw the older men naked. You had no choice. You had to strip with the older men in the same room. The old men had a bath at the same time as I did. You had to go in the same water as the old men and you weren't allowed to change the bathwater. There was a queue to get in the bath. The staff bathed you. You knew you weren't getting properly cleaned. The staff just did a bit here and there. Then you had to get yourself out of the bath and get yourself dried.

'The doctors told my mum and dad they would be helping me all the time, but I didn't get any treatment. There was no hospital in the Royal Scottish National Institution to take care of you. Once, when I was sexually abused by a patient in the bathroom, I put my hand through a window to shout for help and cut my arm. I showed my arm to the staff and the staff weren't interested in my cuts. The staff didn't give me a tissue or bandages. They didn't even help to put a bandage on. I still have a scar now on my arm. None

of the patients were getting any help from the staff.

'There were a lot of drugs that the staff were giving you all the time. You were given a Largactil tablet four times a day, in the morning, at dinner time, at tea time and bedtime. You were out of it. When you got up in the morning you were still drowsy. When the staff gave drugs to the older folk they were knocked out every time. The older folk would be taken up to the ward. This was when the staff were trying them out with injections.

'I didn't have any friends. You weren't allowed to talk to the other children. You weren't allowed to go in the grounds to play. I was in the old man's ward away from the other children. The only time you were allowed out in the grounds was if you were taking part in the football team. I started to play football, but then I stopped it altogether.

'There was a big gym in the same place where the dining room was. You weren't allowed to go in the gym by yourself. The staff had to come with you.

'We didn't go out on any trips. We didn't go into the village. You weren't allowed back home and you weren't allowed any holidays.

'You wore a grey and blue short-sleeved shirt with a jumper and short trousers. You had a body warmer

jacket and you were given a pair of trousers. When you asked for a new pair, they refused to give you more.

'Sometimes you had a ribbon round the sleeve of your arm. Folk asked why the staff put those ribbons on. The staff wouldn't tell you the truth as to why. When you were going to the gym or to watch football at the football fields, you had to have the ribbon on all the time.

'The school was a very nice place. The teacher was good. You made table mats, did drawing, sewed and played with balls. There were nine children in the class. There was no play time and you weren't allowed out into the grounds. You were kept in the hospital building. School only closed between Christmas and New Year.

'My mum and dad sent in birthday and Christmas presents. The staff dished out all my birthday presents amongst everybody.

'My dad had no intention of coming to Larbert, so he didn't visit me. I never saw an inspector there.

'Three boys ran away when they were 13 or 14 years old. They got to the station and on to a train. The boys had been meeting, talking and planning things. Some people would climb out the windows to get into the grounds and climb the fence to get away.

'If you didn't go along with the staff's law, they put you into a strong room with a door. The only way you could get out of the room was if the staff let you out. On one side of the door there was a handle you could open, but you couldn't get out from the inside. The door was made of steel. There was no bed, so you had to sleep on the floor. There was no blanket or mattress. There was no toilet, so you had to do the toilet on the floor. I was put in the room two or three times for three or four weeks at a time. You weren't allowed out for anything such as getting a bath. I was in the room when I was 3 years old. I was terrified.

'There was a lot of arguments, fighting and bullying between the staff and some of the patients. The patients would go to the staff for help and the staff told the patients they weren't there to help. The staff weren't allowed to sit and talk with you and you weren't allowed to talk to the staff. There were times I was upset and lonely, but the staff didn't do anything.

'The staff would sit at the back of you when you were eating your meals in the dining room. If you didn't eat all of your meal, they forced you to eat it. You weren't allowed to leave anything on your plate.

'The staff held you down on the bed. They were on the top of the top half of your body and held your arms

down. They sat on your body and your arms and held your face down on the pillow.

'I started being sexually abused when I was moved to the men's block. I was 3 or 4 years old. One of the patients saw me coming into the block. I can't remember his name. He was about 30 or 40 years old, 5 foot 2 inches in height with black hair. He wore jeans and a shirt. The patient went into the office and put on a white coat. I didn't know he was a patient. He was acting as a member of staff. He filled up one of the baths to the top with cold water. The patient put my head under the water. I got away from him. I climbed up the rails in the bathroom to the window, smashed the window and cut my arm. I shouted for help. Nobody came to help me.

'I got away from the patient out of the bathroom. I got to the attic where all the beds were in the ward. The patient managed to find me. He pulled me out from under the bed and sexually assaulted me. The patient put his penis in my back end. It made me not well. This happened to me five or six times in the time I was in that ward.

'The same patient used to steal money from folk. The staff found out about that. The patient was put into the Royal Scottish National Institution because he

was detained there on a court order. He came into the ward with handcuffs on and was there permanently.

'Sometimes the headmaster at school would cane you across your back. You would be sent to the headmaster because you weren't doing your work right in the class. That didn't happen to me.

'I don't think some of the old men got proper treatment from half the staff. Staff would put the old men in a room and lock them in.

'With every new person that came into the old man's ward, the patient was there with the white coat on waiting to get them. The patient was abusing a lot of folk. He was doing it to old men as well. He would fill the bath with cold water, put them in it and put their head under the water. Then he would sexually assault them. The patient was getting away with it all the time.

'I told the staff about the patient sexually assaulting me but they weren't interested. They were taking the patient's side all the time and making me out to be a liar. The staff asked me who the patient was and he didn't get to wear a white coat again. The other folk told the staff they were being sexually assaulted by this patient but the staff weren't interested.

'When I was a wee bit older, about 9 years old, my

dad visited me. My dad brought a radio for me. When the staff opened the ward door, a patient ran up and snatched the radio out of his hand. My dad took me back home after that. He tried to tell the staff about the radio but none of them were interested. My dad and I travelled back to Aberdeen on the train.

'I was staying with my dad in Aberdeen. Dr Drummond came to my father's house from Ladysbridge Hospital. The doctor asked my dad if I would like a fortnight's holiday at Ladysbridge. The doctor asked me and I said no. My father agreed with the doctor.

'I was taken unwell and my dad phoned an ambulance. I had food poisoning. I was taken to ward 8 at the City Hospital. I was transferred from there to Ladysbridge in an ambulance.

'I went to Ladysbridge Hospital when I was 9 years old. I stayed there until 1989, when I was 37 years old. The hospital was closing then. I didn't know why I was staying at Ladysbridge. Nobody told me why. Even my father didn't tell me anything about the illness I was supposed to have. Ladysbridge wasn't a nice place to live in.

'There were eight wards altogether. Two were female wards called Devon and Fife. There were 52 patients in each of those wards. There were six male wards. One

was called Moore Ward. Four wards with 42 patients and two smaller wards with 19 patients in each. In the smaller wards were patients who had had strokes and couldn't move or feed themselves.

'My ward was called the Sick Training Unit. There were three wards with people like myself. The people in my ward were all different ages. The ward across from the Sick Training Unit was the baby unit.

'The head doctor was Dr Cook. There was a Dr Drummond. There were other staff including the nurse in the charge hand team. They were at Ladysbridge when I was a child. They were stricter. The member of the charge hand team was always knocking us out with injections. Sometimes he would get another nurse to come over from the head office to the ward to knock you out. Neil Munro was the social worker. Some staff wore blue uniforms and some wore grey jackets and trousers. You had to call the staff "Sir". You said, "Yes, Sir. No, Sir."

'I was taken to Ladysbridge in an ambulance. I was 9 years old. I didn't know I was going to Ladysbridge. There were two members of staff there. When I realised I was going to Ladysbridge, I got agitated and managed to break one of the ambulance windows with my foot.

'The ambulance stopped at Woodlands in Cults. Four

staff from Woodlands came into the back of the ambulance and held me down. Two of them were sitting on top of me. A nurse made up a syringe with paraldehyde. They gave me an injection of paraldehyde and knocked me out to sleep.

'When I got to Ladysbridge I was getting up to go to the toilet and saw there were four staff hanging about in the ward. Every time you got up to go to the toilet, those four staff were right over to your bed, holding you down again to give you more paraldehyde, to knock you out. I was getting 100 milligrammes of paraldehyde. I know that because the bottle was a 10 cubic centimetre bottle and it filled the whole syringe. The staff were giving you paraldehyde all the time.

'You weren't even allowed to go to the bathroom to get a shower. Each time you got the injection of paraldehyde you had a feeling of burning in the back of your throat. You felt the taste of it. It carried on like this for years until Ladysbridge closed down.

'In the big wards there was only a space of about a foot between the beds. You couldn't get out of bed to go to the toilet. The toilet was down the stairs and opposite the night staff desk. Every night every ward was locked at 7.00 pm. The ward was locked all night until the morning staff came on duty.

'You were up at 5.45 am every morning. Once you got out of bed, you had to go to the bathroom and wash your face. When I was older, you had to shave yourself. Then you went back in the bedroom and dressed yourself.

'There were nine or ten patients died in Ladysbridge when I was there. My bed was in between two patients in the ward. The two patients passed away and I saw the staff put labels on their toes and all that. I saw the patients being taken out of the ward to the mortuary across the road. The mortuary was part of Ladysbridge.

'The meals were brought to the kitchen on the ward on a trolley. The meals were dished out from there. You didn't have a choice of what you were served with.

'You had to spend all your time in the ward. You weren't allowed to go out of the ward into the grounds to walk about. The only thing you had at Ladysbridge was your church service on a Sunday and your club after church. The church was at the back gate. On Monday and Tuesday you had social club from 5.00 pm until 6.45 pm, when you had to be back on the ward. On a Thursday there was the pictures. The films were shown in one of the big halls in the staff canteen.

'There was a football field but no one used it. One of the patients had their own music. They were told to switch it off and weren't allowed to play it again. You

weren't allowed to go into Banff to walk around the shops. You weren't allowed to join in the entertainment with the patients. There were no games. There were no story books.

'I started smoking when I was 9 years old. You had to be 12 or 13 years old before you were allowed to buy cigarettes. There was a shop that you could buy them in. I got cigarettes from my cousin, who came into the hospital as a patient. He came in for a couple of weeks' holiday to let his sister and brother go on holiday. He had a problem with drinking alcohol. He spotted me and we sat together and had a cigarette. My cousin left Ladysbridge after that.

'I got the belt at school. The school was in Ladysbridge. The staff didn't allow you to learn. I taught myself to read and write. If you did anything wrong, you were taken downstairs and not allowed to mix with the other children.

'The staff were knocking you out with paraldehyde all the time. Every time you tried to protest, the staff would inject you with it. I was still being given Largactil.

'You weren't allowed to speak to a doctor. If you got a doctor and complained about a member of staff, the following day you would find the doctor had told the

member of staff what you said.

'There were a lot of folk visiting, but I never got anyone to see me. I went home to my mum and dad's for one day and then back to Ladysbridge. I did that about three times. I had to be back at Ladysbridge before 9.30 pm. If you weren't back, they would start a search to look for you.

'There was a board on the wall in the ward in the office. There were tokens in different colours. If you got four black tokens you couldn't get any money for cigarettes or anything. You got a black token if you didn't behave. You knew yourself what colour of token you were going to get from the staff. The staff decided what tokens to stick on the board. The colour you got was based on your behaviour and your attitudes to the staff.

'If you gave the staff backchat they would twist both your arms up your back and take you to the bedroom. The staff would get you on the bed and call in the rest of the staff. There would be one sitting on each leg and one sitting on each arm. One would even be sitting on top of your head with your face facing the pillow. You couldn't breathe when they have your head down on the pillow. Other staff would come in and they would knock you out with an injection of paraldehyde. The

injection was in your hips.

'Any time you did anything wrong a member of staff would get you. They didn't say anything to you. The member of staff went into the office and phoned across to the main office to call the nurse to come across. It was this nurse who did the injection. The injection would be five times in each hip before you were knocked out.

'A patient told me to be very careful because the member of the charge staff was passing things on to the nurse. If he saw you doing anything wrong, he closed the door and phoned someone to come across. All of the patients were getting the same treatment.

'Members of staff restrained, hit, slapped and punched patients ... I saw patients being slapped and hit around the face but not children.

'The patients were force-fed. The staff would order the food. You were not allowed to refuse anything. If you didn't like it, you had to eat it. All the babies were force-fed milk from a bottle. I saw it myself. The block I was in was facing straight across to the baby ward. Some of the babies weren't looked after. The staff weren't changing their nappies. Three or four young kids died in their cribs. That's when they started removing the babies from Ladysbridge to

Woodlands Hospital.

'In the Devon and Fife wards patients were abused by staff. One of the nurse's wife worked in the Devon ward. Patients got to her for threatening them. She called in her husband from the other ward to come into the Devon ward to knock all those patients out.

'Some people were paralysed down one side. They were asking the staff for help but weren't getting help. The staff said it wasn't their job to help you with anything. With a lot of the old folk, the staff didn't call the doctor to get them help. There were about 15 people who died in Ladysbridge.

'You couldn't complain to anyone at Ladysbridge. The doctors always took the staff's side. You were always being the bad one. A lot of patients were complaining about the paraldehyde.

'A boiler man was checking the boilers on each ward. He saw what the staff were doing to the adult patients on each ward, forcing them to eat and slapping them across the face and he blew the whistle on it. He wrote a letter to the mental welfare rights people. They received his letter and came into the hospital. The mental welfare people actually saw what was happening to the patients. After they came in, they told the doctors the place was to close down. I left Ladysbridge because

it was closing down.'

At paragraphs 72 to 75, 'Martin' then talks about the impact of his time in the institutions.

He says at paragraph 73:

'I sometimes have flashbacks and I can't get proper sleep.

'When you were down on the farm in the summer, your face and body would be getting burned with the sun because of the Largactil. When you went back to the ward, sometimes they'd give you calamine lotion. I don't take Largactil now.'

Since he has left residential care, 'Martin' has two carers who support him.

He tells us at paragraph 77 that sometimes you can't trust your carers. The carers will go and discuss things about you with other people.

At paragraph 78, 'Martin' tells us about the reporting of abuse at the Royal Scottish National Hospital. He tells us what the lessons to be learned are from his time in care. He says:

'Three years ago, I told one of my carers about the sexual abuse I had suffered at the Royal Scottish National Institution. She said I should report it to the police. Me and my carer went to the police in Bucksburn. I spoke to Detective Inspector Davidson.

The police wouldn't do anything.

'Children shouldn't be put into places like the Royal Scottish National Institution or Ladysbridge Hospital. They should be with their parents. The things that happened to me shouldn't happen to other kids.

'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.'

'Martin' has signed his statement and it's dated 17 December 2020.

LADY SMITH: Thank you very much.

I'm going to rise now for the lunch break and that leaves us with one read-in that's planned for this section, and we can do that starting at 2 o'clock, is that right?

MS MCMILLAN: Yes, my Lady, thank you.

LADY SMITH: Thank you very much.

(12.52 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Good afternoon.

Now, Ms McMillan, you promised me another read-in before lunchtime. I take it that this is the person

with the pseudonym 'Kevin', have I got that right?

MS MCMILLAN: Yes, my Lady, that is right.

LADY SMITH: A process of elimination.

MS MCMILLAN: This is the final read-in for this block of Phase 9.

LADY SMITH: Thank you.

MS MCMILLAN: Block 1.

'Kevin' (read)

MS MCMILLAN: This is a statement of an applicant who is anonymous. He will be known as 'Kevin'. The reference for 'Kevin's' statement is WIT.001.003.0472.

In his statement, he says he was admitted to Ladyfield when he was 7 years old and remained until he was 8 years old.

Records reflect this and show that he was admitted in [redacted] 1975 and discharged in [redacted] 1976.

Thereafter, 'Kevin' spent some time in Thorntoun School from 1979 to 1984.

From paragraphs 2 to 9, 'Kevin' talks about his life before he went into care. He was the youngest of six children. He tells us that his father was an alcoholic and extremely abusive towards his mother.

He went to school at the age of 4 and a half. He says that because he looked different, he was picked on. He was violent towards other children when they were

violent towards him. He had problems with his speech, which made him frustrated and often angry.

Before going to Ladyfield, he went to see Professor Stone in Yorkhill, who said that he was a puzzling case, because he couldn't work out what was wrong with him.

From paragraph 9 he tells us how he ended up in Ladyfield West and what life was like for him there.

He says:

'I wasn't going to school all the time and when I was at school, I was sitting in the corridor. That went on for months. One day, one of the teachers said, "Do you not want to be here?" I said, "No". I didn't want to sit in the corridor all day so of course I was going to say that I didn't want to be there. I think the school wanted rid of me because of my violent behaviour and my behaviour in general. I was basically just a pain for them. I didn't go right away, but they carted me down to Ladyfield later on.

'I was 7 years old when I went to Ladyfield. I think the decision was taken in my absence. I don't know who took the decision. In those days, if you stole an apple, you were carted off to a place like Ladyfield. My mother and biological father were not told that Ladyfield was a mental institute for kids. My parents'

understanding was that I was going to a residential school. A couple of my brothers had attended a residential school during the school holidays, so I was thinking it was similar to that. The word "hospital" was never mentioned to me or my parents. We were told that Ladyfield was a school. It wasn't a school, it was part of Dumfries Royal Infirmary, Crichton, which was right across the road from it.

'Ladyfield East was for older boys. It was separated from Ladyfield West by a hedge. Ladyfield West was a Greek villa. It was massive. It was quite an impressive building. When you went in the front of the place, the first door on the left was the girls' room. The second door on the left was a TV room. The next door was where the doctor took you in. Diagonally across was the office, where you went in to take your tablets. I also took phone calls from my mother in there. There was a toilet to the right-hand side of my room. Downstairs in the basement there was a kitchen and a shower. There was also an upstairs area where you went to see the doctor. The decor was okay. There were toys upstairs. There was a big Portakabin where we went to school, so we never left the grounds apart from on a Saturday morning when we went to the pictures or when we went swimming in the hospital.

'I don't know who was in charge of Ladyfield. I do remember an old guy who smoked a pipe and wore a tweed jacket. He seemed to be one of the people who was running the place. He was older, maybe in his 60s or something. He was in the office a lot. Some of the staff wore normal clothes and others wore white jackets. They were all in their 30s or 40s. I can remember there being about six or seven members of staff. There was a female member of staff who was a sort of nurse, who wore a white jacket as well. There was another guy who wore a white jacket and he was bald and mean. He was well built. I can't remember names of the staff. I can only really remember faces. The only name I can remember is the cleaner, Sheila. She was the only member of staff who was kind to me. I used to help her and she'd let me sit on her knee. The rest of the staff were horrible. They were maniacs, as far as I'm concerned.

'There were only about 12 children in Ladyfield at most. I think all the boys were round about the same age as me. I remember, as the days went by, being in there with kids who were crazy. At one point, I read in a book that there was a child in there for killing another child. I don't know if he was in there at the same time as me, but it made me wonder what kind of

people I was in amongst. Some of the children there were quite violent and they weren't right in the head. There was one person who went there as a child and stayed there for 30 years. I think he had a [redacted] injury. I should never have been sent there. I should have been sent somewhere else before being thrown in with the sharks. I was very confused about it all.

'I first went into Ladyfield in 1975. I remember because it was hot weather. I remember I left in [redacted] 1976. My parents took me there. I became quite distressed there. It says in my notes that I was showing disturbed behaviour. I think it was the staff that were showing me disturbed behaviour. When I arrived I was taken around the place and shown my room. My parents were shown around too, but obviously the staff put on the happy face for them. The atmosphere in Ladyfield was terrible. You could cut it with a knife. It wasn't a happy place to be. You didn't hear many people whistling or singing, put it that way.

'I shared a room because the place wasn't big enough for me to have my own room. It was a room with three beds in it. I don't remember having any problems with the boys that I shared with, but I can't remember their names. I noticed that they were metal hospital beds.

I don't know how my parents didn't spot that when they were shown around. We all went to bed early, but a lot of the time I was in my bed already because that was my punishment. They never locked the bedroom doors, as far as I can remember.

'The washing facilities were down the stairs. We had one shower and one bath. A member of staff would take us down in the morning and make sure we got washed and brushed our teeth. We would queue up. The staff would help me with that and scrub my back for me.

'We had clothes that we would roll about in. We were always covered in mud. We always had good clothes that we would wear to the pictures and things like that.

'There was a dining area in the basement. There was breakfast time, lunchtime at around 12.00 pm or 12.30 pm and then tea time was at about 5 o'clock. I suffered from malnutrition when I was at Ladyfield because they often never fed me. If I was with one of the students or the doctor, that was it, I never got fed.

I shouldn't have been with them when it was meal times. This happened quite a lot. During the period that I was going for medication as an adult and I was in contact with Dumfries Royal Infirmary, Barnardo's got involved. I remember walking in and the Barnardo's social worker said she was expecting to see a little boy. I told her

that I was 45 or whatever I was. She said that she meant that she'd seen in my notes that I had suffered from malnutrition.

'When I did get food, I remember getting tapioca. I can't remember much else. When my parents took me back to Ladyfield we used to stop at a motorway cafe. I was always hungry and I used to demolish an adult portion.

'We had a wee locker downstairs where we used to keep our food. My mum would send me parcels with sweeties and a postal order. One of the boys broke into them and ate everybody's sweeties. I don't know whether he was punished, but we never got our sweeties anyway.

'There weren't many of us to educate, so the school wasn't that big. I think there were a couple of classes. I attended every day from 9 o'clock until 3 or 4 o'clock. The teachers were employed by the education authority rather than the hospital. We were taught how to read books. We also had a cookery class on the other side of the building. I think we used to go there on a Friday.

'Most of Ladyfield was a bad experience, but it wasn't all bad. They used to take us to the pictures on a Saturday morning. It did say in my notes that when I wasn't in the house I was very little trouble. We

were allowed to play on the grounds unsupervised. There were big grounds with a roundabout, swings and a chute. I spent a lot of time by myself out on the grounds. I used to play with a stick. I just did my own thing. I've always had to rely upon myself. Even at that age, I didn't depend on anyone to do anything for me. I couldn't communicate with other people. I was shy. As far as I was concerned, if I was in the house I was a target for those animals. That's what the staff were, animals who picked on children.

'I used to like going swimming at the pool in the hospital grounds. A lot of the times, I'd have to see the doctor at the time I was supposed to go swimming. They must have known I was going swimming. Why couldn't they make it another time? It would have been okay if it had happened once or twice, but it kept happening so I felt like I was being picked on again.

'I think I was at Ladyfield for two Christmases, but I would go home. I don't know how long I got to go home for. We used to get a present from the staff at Christmas time. One year they gave all the other children a gun apart from me and one other boy. I was given a toy car. I couldn't join in with all the other children because they had guns and I had a car.

'When I went through the process of mediation with

Ladyfield, they told me that there were inspectors who came down. I don't remember that, but I know that because they told me it happened. Nobody ever asked me what I thought about the place.

'My parents would pick me up to take me home every second weekend. I would go home from the Friday to the Sunday. I had to go back for school on the Monday morning and it was 70 miles from where I lived. My biological father told the staff at Ladyfield that he wouldn't drive me down the A77 in the winter months because of the black ice. He wasn't getting money to bring me down. He was always pushing for money for petrol. I read that in my notes.

'I was given drugs at Ladyfield. I don't know what drugs they were giving me, but I think they were to calm me down. It was just a case of putting out your hand, taking them in front of the staff and drinking your water. I saw someone who I think was a psychiatrist. But I don't know if that's what he was. I used to lie on a black couch and he would swing a pendulum in front of my face. It was some sort of hypnosis and I used to fall asleep.

'My speech difficulties were very frustrating. When I was at Ladyfield I used to go to the dental hospital at Sauchiehall Street in Glasgow. They would help me to

speak and say different words. There was a lot going on from about the age of 6 or 7 when I left Barmulloch Primary School. I would be going to hospitals. I would be going to doctors. I just got used to it. They didn't know what was wrong with me. My conclusion is that's because there wasn't much up with me. What was wrong was that I had a bad home life, I was bullied at school and I bullied back and then I became more violent when I got to Ladyfield. I was violent to them because they were violent towards me.

'I saw that the staff were better to other kids than they were towards me. There was a boy there who was a couple of years older than me. He tried to bully me, but I bullied him back. He did it in front of the staff but they didn't care. I had to stand up for myself. When I was getting a doing, the staff didn't intervene. If I was giving someone else a doing, they intervened. I remember I was fighting with a boy. I think he might have said something that I didn't like the day before. I attacked him and we were rustling about on the ground. The staff came down and obviously I was put to bed. He wasn't put to bed. I was marked, but I can't remember where.

'I could hear the boy who I'd been fighting with saying at the door of the dormitory, "Come and see what

I've done to him". The staff member, having been told by one pupil that he'd battered another pupil, actually brought him into the bedroom. I don't remember the name of the staff member, but he was a fat guy with dark hair. I wanted to punch the boy again because when I heard that, it angered me. When they opened up the door, I gave them obscenities. I became a very bitter and twisted young man, even more so than before I went in there.

'I remember being outside playing. I saw one of the boys shouting my name. It was the same boy who broke into the lockers and ate our sweets. He said, "Watch this". He threw my toy gun out of the window and it broke. I went to tell a member of staff, the older man who wore a tweed jacket and worked in the office. I told a member of staff because I didn't want to attack the other boy. If I did that, I knew I'd be put to my bed again. The member of staff just laughed.

'If the staff annoyed me and I was cheeky back to them, they sent me to bed. I spent my days in bed because that was where they put me. I used to hide from them up the trees, but then they cut down the trees so I couldn't hide from my tormentors. On one occasion, there was a crowd of us at the front of the house. Somebody threw a stone at a staff member's car. It

didn't hit it. It wasn't me, but I got the blame. I was picked on. The staff didn't like my face. They even wrote that in my notes. I got put into bed. That was normal. It could happen at any time of day. If I didn't go to my bed, I was dragged there.

'One of my main tormentors was a member of staff. He wore ordinary clothes and I think he was in his 30s. He had two or three kids of his own. He was a wee guy and he used to wear big thick glasses. He had a chip on his shoulder and he used to have an attitude problem. He was very sarcastic and he never had a nice word to say to me. I can't remember the kind of thing that he would say to me, but it was just unpleasant. It was 18 months of hell in there.

'One day I was ready to go out the main door. I'll always remember it. It was a roasting hot day. That same staff member said to me, "You're going [back] to bed". I said that I hadn't done anything, which I hadn't. He dragged me by the neck from the front door into my bed. By the time that I was on the bed I tried to kick him in the face. I was going crazy. I had bruises and marks on my neck where he had dragged me. That was the worst incident. It was quite sore. The bruises were there for days afterwards.

'I think I was put to my bed for about nine or

ten months. It could have been more, it could have been less, but I was in my bed a lot. I wasn't the only one put to my bed. I had to stay in my bed until they told me it was time to get up. The only time I was allowed up was to go to the toilet. I didn't have anything to play with in the bedroom. It was no fun lying in bed all day when it was a roasting hot, sunny day. That was when I started to bite my fingernails and my toenails. I was starting to go crazy. I would think about how I hated the place so much.

'On another occasion, I was fighting with a boy. A female member of staff was breaking up the fight. She had a pair of scissors in her hand. I don't remember what her name was, but I don't know why she broke up the fight with a pair of scissors in her hands. The scissors ended up on my face and I had a superficial wound as a result. That's recorded in my notes.

'Anything that happened in the school, I got the blame for it. I was picked on from morning, noon till night. I couldn't open my mouth without them putting me to bed. There was another incident when I was walking by two boys who were in the place. One of them attacked me with a plastic Ninja star and got me in the eye. It gave me quite a bad black eye. That was for nothing. I went to the hospital for an x-ray. It happened down

at the bottom of the woods and I never saw any members of staff nearby. According to a staff member, I started it and the boy was just sticking up for himself. That's in my notes. Whoever the staff member was, he or she didn't see anything.

'I did a prank at school. The teacher wasn't happy. She let me know that she wasn't happy and she tried to hit me. She didn't connect because I moved out of the way. She wasn't very young. I think she was in her 40s and she wore glasses. If she had been younger, she probably would have connected with my head and punched my head.

'I couldn't communicate with people. I was a shy boy. As far as I was concerned, I was being mentally tortured. I was being picked on by so-called adults who were getting paid to look after me. They were getting paid to torture me and other kids. That went on until the day they shut their doors. It went on through the eighties and nineties. Other kids went through it. I'm aware that they ended up with a padded cell in there, but that was after I had left. I'm glad of that, because I would have been in it all the time.

'I had no way to contact my parents to tell them what was happening. They didn't have a phone. They used to use their neighbours' phone or the call box

round the corner to contact me. However, after the member of staff dragged me by the neck, I still had the bruises when my parents came to pick me up for the weekend. They saw them and asked about them. I told them that the staff member dragged me by the neck. It's noted in my records that my parents asked about the bruises. The staff just gave a lame excuse. They hit them with a story. Adults don't believe that other adults will be cruel to kids.

'It got to the point where I wasn't living, I was just existing. One weekend when I had been at home, I refused to go back to Ladyfield. I was hysterical that night. I went into the car and I refused to get back out. I don't remember any staff coming to try and encourage me to go back in. I remember my mum saying that I only had another couple of months and then I'd be home, but I couldn't take it anymore. I never went back. It was in [redacted] 1976 and I was 8 years old. My parents phoned Ladyfield and my place was taken. They got a new victim. They sent my stuff up in a box. They didn't want me back. They were quite happy that I left.'

'Kevin' then tells us he went back to his old school but he struggled there. While continuing to attend Yorkhill, he was taught in the children's ward during

the day and then would return to his home at night, before a new school was found for him.

'Kevin' was then placed in Thorntoun School in Ayrshire and in his statement he talks about his time there, including the routine and the abuse.

At paragraph 84 onwards, 'Kevin' talks about life after being in care.

He had a social worker who supported him with a variety of things, including getting his own flat, but he still struggled. He says he was angry and frustrated. He couldn't read or write and he wasn't fit for work.

'Kevin' went on to have an operation when he was 21 years old to repair his mouth, which had caused some of the speech difficulties when he was younger. He says that that was a turning point in his life. He says that he also went to see a clairvoyant. This was someone he could talk to. She changed his perspective and as a result, he was able to travel the world.

'Kevin' tells us about the impact of his time in Ladyfield from paragraph 90 and his attempts later in life to report the abuse. He says:

'All my life, I thought about why the staff at Ladyfield treated me the way that they did. I've tried to see it from their point of view. One of the answers

I've come up with is that they didn't care because we were there. If I was a good boy, I would be at normal school and not there. We were just bad boys and we were there to be punished.

'I've still to this day got an eating disorder because of what happened to me at Ladyfield. People think I'm greedy. I'm not greedy, but I have to eat because in my brain if I don't eat something, I don't know when I'll next get to eat. I know that's not the case, but I still think that it is because I missed so many meals in Ladyfield. I was hungry all the time there.

'One of my family members mentioned Ladyfield to me. It seemed to trigger something in my mind. I started to ask why I was there. As I got older, I realised that the people there shouldn't have been doing what they did. When I become interested in something, I like to get right into it and know everything about it. Then it became an obsession for me, because I wanted to know everything. I would remember the hospital beds and realise that it wasn't a school. I asked myself what that place was. It was a Nazi camp for children. The only thing they didn't do was sexually abuse me.

'When I was put to my bed in Ladyfield, I really started to hate mankind. I really started to hate

people. I don't like people in general. I'm not a people person. People are bad. I can't love anybody. I have no love. That died when I was at Ladyfield. Being in there changed my whole outlook. It made me stop caring. When you care, you get hurt. In a place like Ladyfield, you can't show your feelings because you do get hurt emotionally and physically. I've never managed to hold down a relationship for that reason. I feel empty. There's nothing there. That's why I like animals. Animals kill to survive, but the human race kills for sport. I don't like watching the TV or reading the papers. I rarely read the internet news, because it's all bad news.

'I can't interact with people. I've never been able to work because I can't talk to people. I'm antisocial. I can't be in a room with crowds. If I don't know people well, I need to leave. I don't like people irritating me and I'm easily irritated, especially when people insult me for no reason. If people annoy me, I'll annoy them back and they don't like it. Cheeky people who want to pick on me for nothing open up old doors and I start remembering things that people have done to me. I decide not to take it, then I become abusive and then they blame me for it. It also works quite well for me if I just ignore people who have

annoyed me rather than being abusive. That seems to annoy them more than being abusive towards them. My doctor once said to me, "Why don't we put you on a desert island?". That sounded good to me. I just needed people to leave me alone. I've always been myself from the days that I sat in the corridors at the primary school until now.

'I'm very shy. I'm used to rejection. I've always been rejected and I know how to deal with that. It's when somebody says yes to me that I have a problem. That's what Ladyfield made me feel, unwanted, unloved, worthless and useless. By the time I got to Barnardo's, it was too late. They tried to repair the damage but I was beyond repair.

'I don't like being told what to do. I know where I want to go in life. I don't need other people messing me about, sheep or shadows. The only thing I can't buy or get in life is the only thing that I've craved my whole life, from when I was a boy. Love is the only thing that I've ever wanted. It's not going to happen. I've accepted that.

'Some people don't want to talk about their experiences of abuse. Maybe they've got on with their lives. I had to stop telling my mother things about Ladyfield because it was making her upset. She said she

didn't want to know anymore. I consider myself to be one of the luckier ones because I wasn't sexually abused. I honestly don't think I could have talked about that.

'I suffer from depression. I've had suicidal thoughts. I've tried to kill myself a couple of times. I didn't see any life. I thought I'd be in my flat until the day I died. It was like being in prison for me. I'd gone from having 40 or 50 acres of land and lots of things that I could do all day to being in a tiny wee flat. I don't like being indoors.

'None of the doctors, psychiatrists or psychologists that I've seen have helped me. I've told them about my experiences in Ladyfield. The clairvoyant was really good at one point. When I felt really bad, I used to go to her because she was the one person who could help me. I'm still seeing a doctor and psychologist, but the clairvoyant was the only one who really knew me. There's nothing the doctors can do for me. I've been everywhere. The last one I saw was about three years ago ... he gave me a letter saying, "This man can't be helped". I don't receive any help now because there's nothing that can be done for me. I'm beyond help so why waste anybody else's time. What they did to me in Ladyfield destroyed me. They destroyed my soul and they

destroyed the love that I would have had for people.'

'Kevin' then talks about his experiences of reporting the abuse. He goes on:

'I read about the guy who set up Ladyfield. His name was Rodgers and he'd been in the Royal Navy. He was a pioneer. He only died five or six years ago. I wish I'd found out who he was years ago because I would have written him a letter or gone to speak to him to ask him whether he knew what was actually going on there.

'Six or seven years ago, I phoned the hospital in Dumfries and said that I wanted to make a complaint. They asked me to come down to Dumfries for mediation. I saw Angus Cameron, who was quite high up at the hospital. I had been down there for three or four times before the mediation. I would tell him things and he would say that they had never happened and that they had done some fantastic things at Ladyfield. He was basically calling me a liar. He had never worked there so I told him that I was there and it was a concentration camp for kids. I had a letter from my mother stating that she didn't know that Ladyfield was an asylum for kids. He didn't even read the full letter.

'There were other people present at the mediation,

people who worked with Angus Cameron. The woman who did the mediation was his friend. I just went by myself. I wanted to him to do something. Angus Cameron tried to get the better of me verbally, but I left him for dead. He didn't like that somebody he saw as inferior to him took him down. I kept my cool and I didn't shout at him. He lost his cool. He also said that he didn't know why I was complaining because I hadn't been sexually assaulted. After he said that, I shut off the meeting. He also told me I would probably never get closure on all this.

'I reported that the teacher had tried to punch me when I was at Ladyfield. Because she was employed by the education authority, they said it was nothing to do with them. They told me I would have to see the education authority. The teacher was working at Ladyfield so it did have something to do with them. They told me that they didn't know who the member of staff was that I had difficulties with, but they could tell me where his brother worked in the hospital and who he was.

'I saw [another] two ... bosses as well as Angus Cameron. I saw the chairman. I complained to him about Angus Cameron and he said that he'd have a word with him. Angus Cameron thought he was the chairman.

He told me that he didn't have a boss. I hit him with questions and he couldn't answer them. He didn't want to answer them. As far as he was concerned, I was just a liar. I told Angus Cameron that I thought he was a liar. I suggested that we take lie detector tests, but I was told that wasn't appropriate. Why would I make up a story all these years later?

'I went to see Cameron Fyfe and he said he couldn't help me because it was so long ago. The hospital said that they couldn't find any wrongdoing in my case. They told me that I was the first one to complain about Ladyfield. It was brushed under the carpet. They fobbed me off. I didn't have much hope that they would do anything anyway. I know the way these establishments work and they just cover things up. They're still doing it to this day with various things.

'It got to the point where I started to think I was the only one who complained. The hospital was adamant that it didn't happen, "Are you sure? A member of staff would never swear at you, a member of staff would never do that". They couldn't find the member of staff I complained about.

'Those people in Dumfries will never destroy my life. I want them to know that. They tried and they almost succeeded. If I had gone down to Dumfries Royal

Infirmary and they said, "'Kevin', we know what happened here, we're sorry about that, there's nothing we can do about it, it was a long time ago", I would have accepted that. Instead they called me a dirty liar and as far as I'm concerned, Angus Cameron abused me by what he said that day. The rest of them abused me by covering it up. They're just as bad as the abusers as far as I'm concerned.'

I interrupt his statement to advise my Lady that the investigation into 'Kevin's' complaints by the NHS is contained in the bundle. In particular, there is a statement that Dr Angus Cameron provided to the police indicating what he had done to investigate 'Kevin's' complaint, and that can be found at NHS-000000136.

LADY SMITH: Thank you.

MS MCMILLAN: 'Kevin' goes on:

'I complained to the police at the same time as making my statement to the hospital. I attended the police station in Dumfries. When I made a complaint to the police, the first thing the police officer said was that he wouldn't knock on any doors to appease me. His name was Jim but I don't know his surname. I bit my tongue and waited to see where things went. I provided a statement to the officer and went right into everything. I don't think they made any further

investigations. He had basically told me right away that he wasn't going to do anything. Later on, I spoke to him on the phone and told him that I was going to complain about him, he said, "Don't swear at me", I hadn't sworn at him. I asked him whether the call was being recorded. I started to wind him up.

'I looked on the internet and managed to get contact details for a guy whose first or second name was Robin, who was in charge of abuse investigations in the Dumfries Police. I had a conversation with him over the phone. He told me that he was told not to investigate Ladyfield any further. He told me that the member of staff I had concerns about was now dead. At least he had the decency to tell me the truth. I thought my ears were going to fall off. I couldn't believe it. I thought I'd finally found the right guy, but he had been told not to investigate.

'I met two senior police officers at Baird Street Police Station in Glasgow. They were dealing with the complaint I had made about Jim and his investigation and had come up from Dumfries. I asked the female officer a question. I can't remember what the question was, but it was a simple question. She said that she was confused. It was a waste of my time. They had no intention to do anything about it. It was too much

paperwork so they just threw it under the carpet again. As far as I'm concerned, the police are liars and they cover up crimes. Some of them are worse than the criminals of Glasgow.

'After that, I just thought the game was up. There was never a proper investigation. I tried my best. I did it all through the proper channels. I did everything right. I never lost my cool with the police once. I never threatened anybody. I never hit anybody. I never shouted or swore at anybody. It still came out the same way. They couldn't care less.'

'Kevin' then goes on to talk about the lessons to be learned and his hopes for the Inquiry from paragraph 114 onwards. He says:

'I wouldn't say a bad word against Barnardo's because it was mostly good. To be honest, I spent the happiest years of my life there. To say the rest of my days had been depressing is an understatement. The only thing that's kept me going is my sense of humour. I tend to laugh things off. Although Thorntoun was a good place, there were a few members of staff with a bad attitude.

'If the staff at Ladyfield had all been kind like Sheila, I think I would have got on better with them. Instead, they wound me up and annoyed me so I would give

them verbal abuse. I think there should be more monitoring of staff. They shouldn't tell them when they're coming. They need to see what kind of people the staff are, what kind of background they have. My mother worked for the council. They could tell her everything about her life before she started caring for any children. They need more checks on the people like that because some people are not suited to working with children. In my experience, there were bad people at Ladyfield and they were getting away with it.

'Ladyfield didn't shut until the late nineties. I've seen things on the internet about kids being locked in the toilets half the night or being battered. The biggest problem with all these places is that a lot of people don't want to talk about it. If people don't talk about it and they don't say that something is going wrong, people just think it must have been all right.

'I don't know how you can stop the abuse, but maybe there should be a hotline, a phone line that people can call and say what's happening. A lot of people don't want to because they view it as grassing. I know a guy who worked in an old folks' home. He reported another member of staff for hitting a patient. He was blackballed because of it. That's what happens. A lot of people don't want to come forward to the Inquiry. If

they've got families, they might not want their partner to know how bad it was or even that they were in a place like that. It can put a lot of people off, knowing that you've been in a mental institution.

'It took them years to get the Inquiry up and running. That was them trying to whitewash it all again, but they couldn't. I don't know how many millions the Inquiry is costing but people have got to be answered. I hope that anybody who has done wrong to me or anybody else is held to account.

'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.'

He has signed that statement and it's dated 13 November 2019.

LADY SMITH: Thank you very much.

That completes the read-ins for this section, is that right?

MS MCMILLAN: It does, my Lady.

I think that completes all the evidence that we can lead today. Tomorrow we'll be hearing from Charlotte Wilson of the Care Inspectorate.

LADY SMITH: At 10 o'clock.

MS MCMILLAN: Yes, my Lady.

LADY SMITH: Very well.

I'll rise now until 10 o'clock tomorrow morning.

(2.41 pm)

(The Inquiry adjourned until 10.00 am on Thursday, 15 May 2025)

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