Scottish Child Abuse Inquiry

Witness Statement of

Howard MITCHELL

Support person present: No

1. My name is Howard Young Mitchell. My date of birth is [redacted]1955. My contact details are known to the Inquiry.

Background

2. I was born in Lennox Castle Hospital. Growing up, my family lived in Lennoxtown. I had peripheral involvement with the hospital in that I visited the place quite often. For example, I would sing with the Boys' Brigade at concerts and I knew people who lived in the staff housing, which was within the hospital grounds. I wasn't unfamiliar with the hospital itself.

3. In 1975, I started work at Lennox Castle Hospital as a nursing assistant before going on to complete my nurse training in 1978. After finishing my training, I worked as a staff nurse in the Adair Ward at Lennox Castle, which was a children's ward. I was attached to the Adair Ward, running a playgroup for the kids. I then got a job as a charge nurse in the adult wards before leaving Lennox Castle to begin my general nurse training in Edinburgh in 1979. I returned to Lennox Castle Hospital for a further six month period in 1982 when I worked as a charge nurse overseeing nightshifts.

4. I worked at Gogarburn Hospital for a couple of years but I also worked at the Western General Hospital in Edinburgh. I did general nurse training and worked in the intensive care unit there for a while. When I left the National Health Service in 1986, I studied at the University of Edinburgh. I initially studied psychology and artificial intelligence. I

ended up majoring in Scottish ethnology. I went on to do post-graduate study round about oral history and learning disabilities, although I never completed my PhD. I then worked as an oral historian on various projects, including working with the Open University.

5. I did some training, writing and film-making about health and social welfare and a contribution to one of the Open University's courses. Part of that work was about Lennox Castle Hospital and film material of it is featured on the Open University website. There was also written material, a reader associated with the course and a course book. They went in conjunction with the film material. I've written some papers for oral history journals. When the hospital was about to close, the hospital management approached me and asked me if I'd be interested in doing something roundabout the closure. I instigated a project recording people's experiences at the hospital. I worked on an exhibition and a film, which culminated in the closure of the hospital in 2002. The exhibition was in the Museum of Social Work at Glasgow Caledonian University. It then went to some local libraries.

Lennox Castle Hospital, Lennoxtown

Recruitment/training

6. I was friendly with the son of the principal nurse tutor at Lennox Castle Hospital. In 1975, this friend's father suggested that we give the nursing assistant role a go. I was interviewed by two members of the nursing management. It was a formal process and I had to provide references. I'd already worked with fencing contractors and done part-time jobs. I did have Highers, but I didn't need any formal qualifications to work as a nursing assistant. What they mostly asked was whether I'd feel okay working with bodily fluids and in situations which might not be pleasant.

7. I started work as a nursing assistant in January 1975. I was a nursing assistant for six months or so, not thinking initially that I'd be interested in doing my training. However, I enjoyed many aspects of working there over that six months and decided to start my

nurse training. When I started as a nursing assistant, I worked in the male section of the hospital block. The female section was along the corridor. My responsibilities were feeding and changing patients and doing whatever was required. I was supervised by the nursing staff. There was a week's theoretical induction in the school of nursing. I think there was also a week within the hospital block, shadowing a nurse who would show you the ropes. There was no training about patient protection, child protection or restraint. The training was more around how to change a bed, make a bed or what to do when you feed someone. At that stage, it was in-house training. There was quite a lot about how to approach someone or who to watch for, specifics about individuals. I can't remember being given any written guidance or policies.

8. There was a school of nursing within the hospital, but like all nursing qualifications you had to experience other nursing settings. You were therefore seconded to places like Stobhill Hospital, community midwifery, Woodilee Psychiatric Hospital and sick kids units across Glasgow. You didn't actually spend a great deal of your time within Lennox Castle, although you did spend some time on the wards there. You might spend two months on a ward in Lennox Castle and then two months on a placement in Stobhill and then come back to Lennox Castle for a month and then go back to another hospital.

9. I finished my nurse training in August or September 1978, maybe slightly earlier than that. The last ward that you were in was one that you could choose. I chose to work in what was the Adair Ward, which was for children. I hadn't previously worked on any of the children's wards at Lennox Castle. When I finished my training, I started as a staff nurse attached to the Adair Ward but running a playgroup environment for the kids.

10. Once I became qualified, there were new nursing assistants starting. The process was more formal in terms of induction on the ward but I don't recall any different paperwork. It certainly had tightened up a bit in the short time since I had trained as a nursing assistant. There were various incidents and reports of poor practices. The hospital was aware of various things that needed tightened up. There were reported incidents in the Scottish press, particularly the Daily Record and the Sunday Mail, throughout

the seventies and eighties. Things were tightened up through more formal induction training for all new nursing staff.

Other roles held at Lennox Castle Hospital

11. After six months as a staff nurse, I got a charge nurse's position. I worked for a year as a charge nurse through to December 1979 and left to come through to Edinburgh to do general nurse training. I returned to Lennox Castle in 1982. My dad had a stroke so I went back to Lennox Castle in order that I could oversee that a bit. I worked as a charge nurse in night shifts. It was a covering remit in that I visited wards during the night to check who was sleeping. I would be based on a ward but then walk around the grounds to visit other wards. I was still living in Edinburgh, but I would stay with my parents for several days a week. I worked in that role for six months before taking a position at Gogarburn in late 1982.

First impressions

12. Even though I had some familiarity with Lennox Castle Hospital, nothing prepares you for working there. I can remember the smell of the place. You tend to talk about the place as a whole but there were individual villas where there were sixty plus people. Each environment was very different from the other, both in terms of the patients who were there but also the nurses who worked there. The charge nurses were permanently within one place. It's very tricky to talk about the hospital as a whole. They then had the male side and the female side of the hospital, which worked quite differently. To generalise gives a false impression.

13. My first impressions were that I'd never witnessed anything like it before. The range of patients and the range of physical, intellectual disabilities was vast. Also, the range of the staff and their eccentricities was an eye opener, even though I'd lived amongst people who worked there. To have them all overtly there and living and working amongst them was quite eye opening. It was a huge range of kindness and concern, both for staff like myself and patients. There was a lot of the 'young boy' and 'old woman', putting their arm around you metaphorically and making you feel welcome.

14. Meanwhile, there was a frenzy of getting the work done. The work involved dealing with many patients who were doubly incontinent. There was one boy who had untreated hydrocephalus from the 1950s. He had an enormous head. He didn't really do anything apart from remain in his cot. He was beside this elderly guy who sat in his bed and smoked a pipe and had one leg. They had some kind of interchange between them. The elderly man sat in his bed and told the boy with hydrocephalus stories all day. There was a mad eccentricity to the whole place.

15. It was very much that staff came in, worked hard, breakfast, change, sit back and smoke for half an hour. It was a mad frenzy of work, work, work, work, then sit back, relax and tell stories. The narratives that were exchanged roundabout breaks were hugely significant at the time and on reflection as well. I have one older sister who was quite a bit older than me. While I wasn't an only child, I didn't come from a house where there was a lot going on. Lennox Castle was such a huge contrast with all this frenzy of talk and work.

16. The talk of the staff was about people and patients. Patients was the term at the time. It came to be residents or service users. There are different terminologies. The talk was about the crazy things some of the staff did and the crazy things some of the patients did. There was an awful lot about what was on the cover of the *Daily Record* and comments on that. It was just a total barrage. What they tended to do was maybe have seven staff working on a shift. They all worked and then they all had a break together. At that time, they wouldn't break up the tea break so that someone could cover a ward. Everybody came together so they could have a breather and a talk.

Culture

17. As a nursing assistant, I felt embraced by the whole system. Once I started training and went to other places and learnt good practice from other places, I started to reflect. I looked back at Lennox Castle and thought, "My God, is that really going on?" During that training period, I looked at Lennox Castle and my perception changed because of my experiences elsewhere. I was also learning to be a professional and learning what

was legal and what was not. I was making personal judgements about the people and practices.

18. Lennox Castle juxtaposed against the more overtly professional nursing aspects of general hospitals, which were much more based around hygiene and good medical and surgical practice. In terms of institutions for learning disabilities, I don't think there was much difference between Lennox Castle and other similar places. It was always termed the Cinderella service because of the funding that was put into it. It was always bottom of the tree per capita. It was also such a long stay institution that there was very little through-put and turnover, very little turnover of staff, very little turnover of patients. That creates a certain kind of environment, for good and for bad. Things are allowed to grow and things are allowed to fester.

19. There are lots of different aspects of culture. It's always been my hope and desire to reflect on the grey areas and highlight the bad and the not so bad as well. One of the good things was that there was a core of highly trained, professional nursing staff. They worked face to face, finger to body with the patients throughout the whole hospital every day. I've subsequently had experiences in other contemporary care settings where highly untrained staff are almost solely responsible for a range of people with learning disabilities in a one-to-one or a very small but closed environment. That contrasts greatly with a group of professionals who have a structure and a hierarchy, who can see and look after someone who is maybe not as professional as they should be. I'm not saying it always worked that way, but that kind of theory is in contrast to some contemporary settings. I'm not arguing that these large institutions should be here just now, but that was one of the positive aspects. There were professional and highly caring people, ridiculously looking after sixty people within a ward. Many of them made sure that they were as well looked after as they could be within these circumstances.

20. The negative aspects of the culture were that it seemed to be very difficult to get rid of people who weren't patient orientated and were unprofessional, who were either anachronistic or outright cruel and took advantage of their positions of authority. That's one of the things about learning disability: even the worst of the untrained nursing staff

is intellectually superior to the people they are looking after with learning disabilities. If you're not so empathetic and not so bright, it's very easy to think, "Oh, this is great, I can order people about." The flaws in people's character can be very easily nurtured by the power that they have over a range of individuals.

21. There were some bizarre and totally eccentric medical staff who, in my opinion, shouldn't have been in their positions. There were also a huge number of ancillary staff who worked in the sewing rooms, the gardens and the laundry and had an awful lot of contact with the patients. Many of them were fantastic. There were relationships that went on for a number of years. Those staff weren't in the position of having to control patients as much within the ward and were therefore able to have much more of a social relationship with the patients.

22. Staff frequently gave patients nicknames, particularly in the adult wards. I can remember one patient being called 'the beast'. He was one of the few people that seemed to be restrained. If not, he would just wander about and flail out, potentially in pain, discomfort or whatever. There were lots of animal nicknames, 'piggy', 'the penguin', 'broken arse'. The individuals would be aware that they were being called those names.

23. I don't know what the culture was amongst the medical staff and physicians at Lennox Castle, but I can speculate. It seemed to be a repository for those who had failed in some other aspect of their medical career. It wasn't glamourous and there was so little to pinpoint, to cure, to make any forward progress. I think for many it was a societal choice in that you got this great big house in some of the most wonderful countryside in Scotland and you had control over your fiefdom. It was a good life and fairly well paid. It didn't have much of the hassle and demands of a proper hospital career or of a GP.

24. I got friendly with quite a few of the men in wards that I worked in. I wouldn't say that I socialised with them, but I took them into Glasgow and visited them when they left the hospital. One of them was [redacted] who died of an epileptic seizure. His take on it was that the good ones all left Lennox Castle and only the bad ones stayed

behind. If you do stay on, do you become bad? If you've got any gumption about you, do you stay? I'm not saying that's universal at all. Lennox Castle was a good wage earner for many people who might otherwise have worked in the Post Office or something like that. There were a lot of husbands and wives who worked shifts opposite each other. They got a double good wage and a time structure that allowed them to bring up a family. They were very well off compared to many other people in similar situations.

Layout

25. There were workshops, kitchens, a bowling green and pavilions, a football pitch, the main hall, admin buildings, wards, staff housing and the school of nursing. There was a hospital block, which was where I started initially. Most nursing assistants would start in the hospital block, which supposedly catered for patients in the hospital who were ill. There was a male end and a female end of that, joined by a corridor. It had a small operating theatre as well. There were very few patients there who weren't long term. The majority of them stayed there and you'd get a turnover who were actually ill, spent a short time in the hospital block and went back to their wards. I would say that about 75% of the patients in the hospital block were long term. They were some of the more frail patients who spent most of their time in bed. There was a guy who had been a soldier and had developed brain encephalitis. He couldn't talk very much. He basically lay in bed. I was always impressed by the way sort of motherly nursing assistants would spend so much time with him. They would sit on his bed and tell him what they'd been doing. Although he couldn't speak, it was obvious that he could comprehend. There were all sorts of bizarre pockets of great empathy and care.

26. There were male and female sides to the hospital. The landscape lent itself to the male side being at the bottom of the hill and the hill went up to the female side. All of the villas had the same floorplan, but some of the female villas had an upstairs and downstairs. They were originally designed so all of the patients could go over and have their meals externally. I believe that quickly became impractical not long after the hospital was built so there were dining rooms within the villas. There were two wards off a long corridor which had treatment rooms on it. In the early days, some of the staff

slept within the villas. There was a large dayroom where the radio and the TV were and some of the patients sat about there. There was a dining area and kitchen.

27. In the male side of the hospital, there was a staff dining room. Above that, there were rows of rooms for male nurses and other staff as well. In the female side, the 19th century Lennox Castle building contained a nurses' home. There was also the staff housing, which was a couple of hundred yards from the villas.

28. When I was at the hospital, there were probably around about 1600 patients there. I think there was almost the same number of employees, although that was the totality of the employed staff there. It was a huge local employer, although initially the employees at the hospital weren't local at all. They had a policy of not employing people from the local communities. The employees were people either coming to live in or people who commuted into the hospital. That gradually changed and eroded post Second World War.

29. The criteria for people entering the hospital were that someone was labelled a person with a learning disability, a mental deficiency as it was at the time. That was a medical definition which everybody had to have in order to be admitted. The range within that was huge. There were people that you would not know had any kind of mental disability at all. They would work outside the hospital on farms or other jobs within the local community and then come back into the hospital, really as a kind of dormitory. There were also people who had multiple physical and mental handicaps and couldn't walk or talk at all.

30. The wards were designated. Some would be high grade wards and some would be low grade wards. The high grade wards would be for people who were intellectually more capable. There was a medium grade as well. Within that sixty, seventy people unit of a ward there would still be a broad spectrum. You needed that for a workforce. If the majority of patients were low grade, they needed looking after. They needed patients or residents to help the staff look after them. You always needed a mixture of patients. As the hospital progressed along the way, the more physically able people

admitted became less and less. The hospital population was physically much more frail.

Staff structure

31. There was a medical hierarchy at the hospital. The physician superintendent was ostensibly in charge of everything within the hospital and the decision making in medical terms. Doctor McGilvery was the physician superintendent when I was there initially. He retired and was replaced by Doctor Thakur. There were two large, detached houses. The physician superintendent lived in one and his deputy lived in the other one. There were little detached houses where some of the other medical staff lived. Some medical staff lived within the staff housing of what was called the Oval.

32. There were doctors who would be participating in psychiatric training. They'd spend probably a year at the hospital. They could either stay on for a full time position or leave. There were permanent doctors who would be either working on research and visiting the wards to make sure everything was okay. There was then the physician superintendent and his deputy above them.

33. Some of the doctors visited the wards quite regularly, had a good relationship with the staff on the ward and knew the patients well. Some of the doctors would not have known the names of any of the patients and had a hostile relationship with the nursing staff. It varied a lot. There was also this element of physicians doing research. That worked on a totally different level. The nursing staff were dealing with the day to day challenges of life within a ward. The medical staff were totally removed from that. If their interest was research, it was very much interaction with one or two patients over a long term.

34. There was a management to do with the estate and the buildings. There was a nursing management structure as well. As a nursing assistant, I reported very locally within the ward. I was at the bottom of the ladder so the hierarchy would be pupil nurses, student nurses, enrolled nurses, staff nurses, charge nurses, who were all ward based.

There was then management, who would be office based. They'd have a certain structure as well.

Children

35. There were two children's villas, one called the Adair Ward and one called the Leslie Cox Ward. I didn't work in them until the end of my training. The Adair Ward was generally for younger and more physically disabled children. The Leslie Cox Ward was for slightly older and slightly more ambulant children. There would be crossover. They were mixed with boys and girls. They were usually for children up to the age of sixteen. The youngest child that I was aware of was three when I worked there, but I believe they admitted some as young as under a year old over the time of the hospital.

36. The two children's wards had approximately 40 children each. However, most of the wards had under eighteens as well. I would estimate that there were maybe 90 or so children on the children's wards and, just off the top of my head, I would reckon there were another 150 under eighteens in the adult wards. On a ward with 40, 45 children there would probably be five staff working. There would be a charge nurse, a staff nurse and student nurses. That varied as the day went on. There would be less in the early morning. There were also kids going to playgroup or educational units within the hospital during the day. At different times of the day, there were different ratios. Staff didn't take their breaks together in the kids' wards, where more vigilance was needed than on the adult wards.

37. Children were mostly addressed by their first names. I'm not aware of children being referred to by numbers. Sometimes they were addressed by their second names and sometimes by nicknames. Within that, it depended on the individual staff member as well. The nicknames were conjured up by staff, depending maybe on what the kid looked like. I would say that happened with much less frequency than in the adult wards. There were some terrible nicknames within the adult environment, much less so with the kids who were still "cute" in many ways. Even though patients had behavioural and multiple physical disabilities, when they were young it was different.

Most of them were still cute and had the propensity to bring out maternal or paternal feelings as well.

38. There wasn't the same delineation of high, medium and low grade within the children's wards. There was much more of a mixture of abilities within the one unit. It was rare for children to be involved in looking after other children on those wards in the way that happened in the adult wards, but there were the 'big girls'. The big girls were those from high grade wards who would, as their job, come and feed, change and help the kids in the kids' wards. It was a practical thing. There was a demand to be fed and lots of the kids needed fed. Some of the kids had difficulties swallowing and couldn't feed themselves at all. If done properly, some of the kids needed forty minutes to an hour to be fed well. The sheer logistics of that meant that there weren't enough staff to do it. The big girls, who were women up to the age of sixty, would help a lot with the feeding.

39. It wasn't necessarily positive from a care perspective. Feeding can be very demanding of expertise. On the other hand, I'm sure many of the big girls would say that they were more experienced than the nursing staff who were new to that environment. There was also some kind of continuity of care in that the big girls formed relationships with the kids over the years. There was a term in the female side called your 'deary'. A staff member could have a deary, which was a patient that they really liked, favoured and looked after. Some of the big girls had dearies amongst the kids. That relationship wasn't necessarily mutually beneficial. It wasn't always well done. There was often a co-dependency, not just among the children. Decades of co-dependency meant that there was abuse going both ways.

40. Historically, there was a juvenile section at Lennox Castle. There was a physician superintendent in the fifties who took an interest in juvenile delinquency, which was the moral panic at the time. He welcomed quite a lot of juveniles into the hospital and had a methodology for looking after them. There didn't seem to be much to the methodology, other than to treat them with kindness and football. My knowledge is based on reports from people who worked there, who also didn't seem to have much passed onto them about how to treat the juveniles.

41. The juvenile ward was for aged twelve to sixteen or eighteen. It was for teens who were bunking off school or stealing bikes and deemed to be slightly on the spectrum of learning disability. It was a kind of mini-borstal regime within this brew of care, maternity unit and children. It had a school as well, which mostly seemed to be run by nursing staff. Many of the people from Lennoxtown remember that they used to go on runs and marches throughout the town. The boys were easily identified because they all wore big red socks.

Routine at Lennox Castle

Admission of children to Lennox Castle

42. A child might be admitted at a very young age if he or she had Down's Syndrome. It was always connected to social circumstances. It was never the extent of someone's mental or physical disability, it was whether someone's social circumstances allowed them to be cared for and supported at home or there was a desire from parents to care for them. On an individual basis, I'm sure it would often have been felt that it was the best thing for the child to be taken away and put in an institution. There were obviously a lot of recommendations for that kind of thing from medical staff.

43. I can remember a man who had quite severe epilepsy. He grew up in a very professional and supportive family. He was put into Lennox Castle when he was in his early teens. His brother said that there was just nowhere else for him to go, at all. The family were well off and had a very supportive family environment, but he said there was nothing else offered to them. Lennox Castle was what was on offer from the wider medical and social community.

44. There were satellite institutions, like Waverly Park, in and around Glasgow. They were smaller units which tended to have some of the more able kids. They then maybe transferred to Lennox Castle after that. I certainly worked in one of the women's wards, Villa 8, where there quite a few teenage girls who had been living in those units and

transferred in. They were very able people physically and pretty able intellectually as well.

45. Some of the talk amongst the staff would be about why those girls were in there. Some of them might be there because of circumstances in their home and family lives. They might have been involved in prostitution or they weren't being looked after properly. They were open to exploitation and living in terrible circumstances. That might sometimes have been a reason for admission. However, one of the bizarre aspects of working in the hospital was that case notes weren't held on the ward. The nursing staff weren't party to case notes so there would be almost zero knowledge for the nursing staff about the social and medical backgrounds of the patients they were looking after. That certainly wasn't the case in Gogarburn, which is the only direct comparison that I have. I believe that after I left, the case notes did come down to the wards but that was not the position for the majority of the life of the hospital.

46. I think there was a mixture in terms of who placed children at the hospital. It could be a family member, social workers or healthcare professionals, but I think that one of the medical staff would be the final arbiter of admission. I was never party to that process because that was all external.

47. Adults would go into the hospital block when they were admitted to Lennox Castle. They would spend a week or so there being assessed in some way. I don't think they did that with the children. I think they went straight into the wards. I wasn't party to that. There weren't many children admitted when I was there. It was a case of there being a new kid being admitted, here they are and some anecdotal story about their background. Children were settled in very much on an individual basis. During my time on the children's wards I can remember maybe four children being admitted. It was all very much responding to the person that was there and their needs and challenges. There was no settling in process. There would be observation and reaction.

48. I can remember a twelve year old coming into one of the adult wards during my training. Just as an illustration, he was supposed to have killed an infant sibling. That was known because of word of mouth. There was no, "This is his casefile." Things

dripped down by word of mouth that this had happened, we should keep our eye on him and he was in an adult ward because of what had happened. The boy had no speech and a fairly severe learning disability. The impetus for him being admitted to Lennox Castle was this supposed accident within the home. It was unusual for a twelve year old to be in the adult wards, but there were many sixteen and seventeen year olds.

Mornings and bedtime

49. Like the adult wards, the children's had two sleeping dormitories off a long corridor. In the Adair Ward, where I worked, one side had cots with cot-sides. The other dormitory on the other side mostly had normal beds without cot-sides. There was more space between the beds than in the adult wards. There were no curtains between the beds. Curtains weren't introduced to Lennox Castle until the mid-eighties. There was no privacy between beds before then. After people had got dressed and gone for breakfast, they put soft toys on the beds. I don't know if it was some kind of signifier that it was a kids' ward, not that the kids ever got to play with the soft toys.

50. The night staff would finish at 7:00 am and the day staff would start at 6:50 am. There were several children who might get up and dressed by the night staff. The majority would be woken up by the day staff or got up by the day staff. You'd have so many in the ward with the cot-sides and in the ward with the beds responsible for washing and dressing the children. The 'big girls' wouldn't come in until about 8:00 am and then they'd help with getting children up, clothed and breakfast.

51. Bed wetting was part and parcel of every morning routine. There were never any punishments for bed wetting, as far as I can recall. It was so universal so nobody would be blamed for wetting the bed. The staff just got on with changing somebody. During the day, some of the big girls would be responsible for changing those who were incontinent.

52. If a child needed the toilet during the night, there was a toilet at the bottom of each ward. There weren't many who were physically able to go to the toilet. The majority of

the kids were incontinent so they would have some kind of nappy on at night. They were still using terry-towelling nappies then. There would therefore be a bed round every so often to change them during the night, depending on the diligence of the staff.

Mealtimes/Food

53. There was a dining area with a serving hatch. Those who were ambulant and could feed themselves would go to the hatch. Most of the kids needed help with feeding. In the day room side, where many would be non-ambulant and sitting about, people would be fed in that area. Mealtimes were always understaffed and under pressure. Lunch was from just after 12:00 pm. The backshift started at 1:00 pm so it was always a scramble for everyone to get fed so you could go home and the backshift could come on.

54. I never really encountered children not liking the food. Everyone was so used to the limited meals that were available. Most of the people being fed had some kind of liquidised diet so it wasn't an issue. Of those who were ambulant and could in some way feed themselves, I never came across people refusing meals. Most people were either fed or could feed themselves. There was no choice. If they were hungry, they ate. There might be a metal container with cold meat for sixty people. You'd have tongs and would maybe toss it onto a plate. Perhaps some staff might not use the tongs, but I never encountered food being thrown towards an individual.

55. Staff didn't eat meals with the residents. Sometimes, there would be something leftover and the staff would go to the staff duty room and eat there. They never ate with the residents. One of the worst jobs as a nursing assistant was peeling sixty boiled eggs in the morning. There was what would be termed 'normal food'. There were eggs, bacon, porridge and sausages for breakfast. There were soups, stews, cold meats and even a salad now and again. They'd all be brought in the meal van. The food was cooked centrally in the hospital and patients would bring food in from the van in bain-maries. They'd be kept hot there and then served out or delivered out to the ward. Some of the liquidised food would be liquidised within the ward setting.

Washing/bathing

56. Generally, there were bath nights. Seemingly, an anomaly of the heating and plumbing system was that you couldn't have all the wards using the hot water at the same time. Ward C would have Tuesday as a bath night, Ward B would have Wednesday and so on. On that bath night, it was an attempt bath almost everybody on the ward. Generally, there was no privacy whatsoever. There were queues of naked men waiting to get in and out of the bath and get dried. Baths were supervised, although a special privilege was that some patients would be granted the bath key and allowed to go and bath themselves. They tended to be patients who were out working and were very responsible. Other than that, it was totally supervised by the nursing staff. All the staff were extremely aware of the potential dangers around baths as there had been a death at Lennox Castle due to scalding.

57. It was less of that routine within the kids' wards, who tended to be bathed as necessary. There was a lot of bathing because there was a lot of incontinence. I think there may even have been a bath book where people were ticked off so nobody slipped through. There was zero privacy in the children's baths either. There were no showers. The bathrooms had two baths and no division. There were no taps. It was a bath key, which was kept in a locked cupboard and used to turn the water on and off. I think that bath water was changed between baths, but it wouldn't surprise me in the least if that didn't always happen. I don't remember that being part of a normal pattern.

Clothing/uniform

58. In the adult wards, there were communal clothes at that time. In the Adair Ward, the kids had individual clothes that belonged to them. However, these were only utilised at weekends and on Wednesdays, which were visiting days. If the staff knew that a relative was coming to visit then they'd have their own clothes. The rest of the time the children have communal clothes. The communal clothes weren't institutional, like the adults'. A lot of the adult wards had battle dress left over from the armed forces, still being used in the seventies and eighties. They also had moleskin trousers as well as sports jackets and normal trousers, but there was a lot of bizarre institutional clothing.

The communal clothes for kids tended to be normal shirts, jumpers, knickers, underpants and things. Footwear wasn't communal and kids had their own shoes.

59. Historically, if someone ran away they'd be put in a moleskin suit to identify them as a potential runaway. When I worked for the Open University, I used to do a question and answer session. The moleskin suits raised more questions than everything else about Lennox Castle put together. They were brushed cotton, a wee bit like sheepskin on the inside and smooth on the outside. They were mousy grey. There were moleskin suits, which were like a whole boiler suit, and moleskin jackets and trousers. On the women's side, there were moleskin wrappers or dresses. When I was there, they were used for patients who tore their clothes. You could put them on back to front and button them up the back so that people couldn't rip them off. They were very hard wearing and strong. They were also used because a lot of the patients liked the feel of them and chose to wear them. I never saw moleskins being used in the children's wards.

60. There was a laundry building which all the washing went to. It was the subject of great angst because some of the clothing that the kids got was quite good. The laundry was always held to blame for ruining the clothes. Sometimes, the nurses or nursing assistants might handwash some of the very good clothing but generally they went to the laundry.

Leisure time/socialising

61. I ran the playgroup in the Adair Ward, which involved going to a separate building about a hundred yards away. The kids would be taken there at about 9:00 am. The playgroup coincided with legislation that every child, no matter their ability, had to have educational input from registered teachers. Next to the playgroup building was the school building. The playgroup's function was to ferry the children back and forward from their half hour's educational input during the day and then keep them engaged in music or other activities between times. Apart from that, leisure time involved limited walks. There was a playground with swings and roundabouts but it wasn't really in use when I was there. I think the majority of the children would have benefitted from that

physical playground aspect, but it had become damaged and wasn't repaired properly. There wasn't much more than that by way of leisure.

62. There were Christmas parties and Halloween parties and all the customary calendar events. Within the playgroup, there were lots of toys. There were a few toys within the wards but nothing personal. The kids in general didn't play with toys the same way as they would within a home environment. That was partly due to their individual disabilities but it was also because they weren't taught to play. I think that you need to be shown examples of playing and it wasn't generally a kind of play environment. It was a regime environment rather than a play environment.

63. The children didn't have free access to the grounds because they were unable to look after themselves. There were some runaways amongst the children, not running away to escape but just because they liked being out of the ward and running. They would be caught and brought back. They weren't escaping like some of the adults might escape. They were just running for the pleasure of it. Sixteen and seventeen year olds on the adult wards would have had access to the grounds. Some of the adult wards were designated open and some were locked. People went in and out of all the locked wards, but they'd have to ask the staff. Certain people were allowed out and certain people were deemed unable to be let out. Both the children's wards were locked.

64. Those young people who were in an open ward were able to socialise at certain times. Many of the patients had a job, such as working in the gardens, the kitchen or the laundry. Some went to sensory training, which was like play therapy. Many of these jobs would involve crossing from the male side to the female side. There would be men and women in the work environment. There was that element of being with other people from other wards, male and female. There were also leisure activities like cinema and dancing. There would be intermingling at religious services, which took place on the grounds. There was a Jewish ceremony, Catholic mass and a Church of Scotland service. Some did go to church services outwith the grounds. On locked and unlocked wards, you might ask who all was going to the dancing. You'd go down to the door and twenty patients would be lined up. You'd count them out and a junior

member of staff would walk them up the hill to the dancing. It was similar when they went to religious services. It was all voluntary.

65. Sixteen and seventeen year olds on the adult wards wouldn't have been allowed to have sexual relationships, but there were different types of relationships. There was a fair bit going on when it came to male and female relationships. The grounds were vast. There were lots of places to hide away. There would be outside sexual relations between male and female patients. There would sometimes be male and male relationships within the ward, but they were totally clandestine. I never witnessed anything of that. If people were known to be in same-sex relationships, it might result in some kind of nickname calling from the staff. The patients wouldn't have been educated about these kind of relationships. They would not be condoned.

Schooling/education

66. In about 1977 or 1978, legislation came into force that every child, no matter their intellectual ability, required to have some educational input from a registered teacher. The playgroup building was next to the school building. They were really the same structure and side by side. Educational input was on weekdays. Children received half an hour daily from a teacher. It was the centre of great angst and controversy because the nursing staff felt that all they were doing was holding the patients there. They'd be brought back if they were incontinent and needing changed. All they were doing was maintaining the care of the patients while they were shipped in for a quick half hour. It didn't work very well. As far as I'm concerned, it was a tokenistic thing.

67. There were also various drips of psychological education kicking in. The psychologist Skinner had written about operant conditioning and training patients. That was done by nursing staff. They would try to toilet train or alleviate aggression and things like that. People would be put on a programme or regime to try and improve an aspect of behaviour and modify that behaviour. That was coming in around that time and several nurses were sent on behaviour modification courses to become nurse specialists. I think it was the latest flavour, but I don't know what the impetus of that was at Lennox Castle.

68. Things were done to help a child communicate if he or she was non-verbal, but it was very individual. I worked on a ward where there was a fifteen year old with cerebral palsy. He was obviously bright and could communicate. I tried to set up some things so that he could shake something for yes and no. It was totally on an individual basis. You were fighting against the weight of scepticism and trying to get everybody to be part of the uniform ward population. The behaviour modification introduced certain elements of toilet training, aggression and some aspects of communication but it was just in its infancy when I was there. There was a speech therapist, but I never saw that person. I know that there was a music therapist in the early 1980s, but I never knew that person either.

Healthcare

69. Medical records were held centrally. Treatment was recorded on the ward in terms of prescription. There was also a patient folder which was a nursing folder. It contained any incidents or anything that needed to be recorded about behavioural changes or anything like that. Medical case notes, containing patient history, ongoing treatment, research or social work, were held centrally.

70. Patients were supposed to be reviewed annually by the medical staff. It often consisted of thirty seconds and a look: "How is he?"... "Fine". Healthcare would generally be the responsibility of the nursing staff. Other than the annual review, they might notice something and ask the doctor to come and look at the patient. The doctor might then prescribe medication or treatment. Medication was reviewed in a similar way. The nursing staff would usually bring anything that might need reviewed or adjusted to the attention of the medical staff.

71. A huge number of patients were prescribed anti-convulsant medication. Many of the patients had a learning disability caused by the same injury that provokes epileptic seizures. Many of the patients had seizures, some controlled well and some controlled not so well. The management of epilepsy was huge in terms of medication and also for the nursing staff when it came to preventing further injury. A lot of patients, staff

and regimes at Lennox Castle came from Stoneyetts Hospital near Lenzie. It was called an 'epileptic colony' and had been going since the nineteenth century.

72. Largactil and Mellaril were the two most commonly used anti-psychotic medications. They were used to sedate and control behaviour in some cases. They would be used in children. There were legal protocols when it came to medication. There was a Kardex and medication was prescribed, signed by the doctor. You had a ward round and you would administer medication and sign off the Kardex. Undoubtedly there was some overuse outwith the prescribed medication, but I didn't observe much of that. There could have been a freedom for those who were corrupt enough to do that.

73. The terminology used by many patients was that someone was 'high'. That meant that they were violent, angry, aggressive. Someone might have been written up for something like 200 ml of Largactil as necessary. If they were off it and causing trouble, they would be given that orally. There was also paraldehyde, but that was really being phased out by the time I was at Lennox Castle. It was an intra-muscular injection and it had more of a sedative effect and acted more quickly. You had to use a glass syringe because it melted a plastic syringe. The terminology used was 'the needle': "You behave or you'll get the needle." It would be written up PRN, as necessary, for somebody who was known to be on occasion aggressive. They could be administered paraldehyde at the discretion of the nursing staff. It did feel that there was a correlation of it being used as a punishment. Although there could also be very valid clinical reasons for giving it, I've no doubt that it was also used as a threat and a punishment.

74. Medication was given to patients at breakfast, lunch and tea, usually at the same time as a meal. A lot of medication required to be given on a full stomach. There was a trolley where all the medications were contained in jars and bottles. There wasn't an individual bottle or jar for an individual patient. There would be a bottle with a hundred phenobarbitone in it. You'd take out two for this person, two for the next person. You'd go to the person while they were eating or post-meal and give them their medication. It was sometimes quite chaotic. There was a culture of memorising everybody's medication and that being a good thing to do. The charge nurses saw it as efficient and as saving time. Inevitably, it was an aspirational thing for the rest of the staff to do

that. There were some staff who had a jug of water and two spoons. They'd use a spoon for the pills or liquid in someone's mouth and use the same spoon for the next patient. Not many did that, but I do remember that happening. I also remember some having the drugs trolley and their ashtray there as well so they could smoke at the same time.

75. The use of laxatives and enemas was widespread but it was widespread for good reason. If you get constipated when you're epileptic then it can quickly bring on a convulsion. If people are sitting about and not exercising, they can quickly become constipated. Although there was an obsession with laxatives, it was based on some kind of sound reason. They had enema days when so many people who needed it would have their weekly enema. There didn't seem to be the same preoccupation on the children's wards and they didn't have enema days.

76. If there was an obvious link between what caused their learning disability and some diet or medication that could manage that, then a patient's condition might be reviewed more frequently. For example, if someone needed a special diet for phenylketonuria. For the vast majority of people at Lennox Castle there was no aetiology. A person might be there, aged thirty, with an obvious learning disability, but we didn't know why. They were there, long-term, within the institution. In children, it may be more acute but they were generally fairly similar. They did have a learning disability, but they had been admitted to the hospital. It was up to the hospital to care and control. There were ward rounds, but the ward round consisted of a physician coming round saying, "Any problems?" ..."No."..."Okay." It didn't involve going around and checking on every individual patient.

77. There were medical staff who were very interested in the progression of diagnosis and treatment of congenital or pre-term causes of learning disability. They would do research and papers. There is a publication called the Lennox Castle Papers. It publishes the research and findings of some of the research that went on in the 1950s and 1960s. Medical staff might therefore have their own projects around that and a limited number of patients who they would review in depth and chart their progress.

That was very much the minority. The majority of patients were seen as long-term, incurable and requiring care and control.

78. A dentist came to the treatment centre, which was in the hospital block. Patients would be referred to the dentist. There were no routine checks. Nursing staff would identify patients who might need dental treatment, but it was hugely lapse. Many people could have been in a lot of pain. The toothbrushing routine wasn't in any way fool proof. If you couldn't brush your own teeth, your teeth might not get brushed. There was a degree of oral hygiene which involved using sponges to clean people's mouths. A lot of patients had their teeth removed. There were a lot of drugs that promoted gum disease. Extractions were quite frequent.

Review of care/placement

79. Reviews about whether patients required to remain at the hospital would not be something that took place within the ward environment. That was something for medical staff and social workers, who were beginning to make more of an appearance within the hospital in the seventies. They had some kind of liaison with the outside world and relatives. A socialisation movement was beginning to grow where people would go to learn to use washing machines and irons and prepare for a future outside. That was for the very able people. For the people who weren't so able, it was totally dependent on the home circumstances and whether they would be welcomed and wanted at home and whether the support would be there.

Trips and holidays

80. There were holidays. There was the annual bus run, which went to somewhere like Ayr for a trip to the beach and an ice cream. There were some respite holiday places that were set up. I was never party to that with the kids, but I was with the adults. They were few and far between.

Work

81. In the Adair Ward, none of the children were able to work. In the Leslie Cox Ward, I think one or two of the children were able to do jobs. They would tie laundry, take it to the front door or bring in food from the food vans. They weren't paid for that. I'm not aware of any children being paid in cigarettes, but that did happen on the adult wards.

82. In the mid to late seventies, a benefit came into place called a non-contributory invalidity pension. Every patient in the hospital had so much per week allocated to them and it was administered within the ward. It was used to buy whatever the staff deemed that the patients needed or, if the patients could handle money, it was given to them to spend themselves. Some might buy sweets or lemonade, others might buy pipe tobacco or cigarettes. That was how money ran within the wards. It wasn't actually payment for doing any particular job. It was rations, but it was paid for with the patient's own money. That system could be used to discipline patients. In terms of cigarettes and tobacco, it could be withheld but I don't think it often was. If it wasn't distributed it would cause havoc because so many patients were addicted to nicotine. You could cause more trouble than it was worth to withhold it. I think it was more often used as a threat.

83. Sixteen and seventeen year old children who were on the adult wards would work if they were able to. Some able-bodied patients went out to work on local farms and other places in the local community. They would be paid directly by the farmer or whoever they worked for. Quite a lot of them lived in temporary huts which had been built during the Second World War. They complained that they were having digs money taken off them by the hospital.

Birthdays and Christmas

84. Those who had relatives who visited would have a visit or be taken to the shop on their birthdays. I can't remember birthdays being made a big thing of for any of the kids who didn't have regular visitors. Perhaps that's my memory being hazy. I was often in the

playgroup so I wasn't in the ward full time. I didn't see the same routine that others might have.

Personal possessions

85. Children didn't have areas to keep their own belongings in. In the wards without cot-sides, there was a locker underneath the bed. They sometimes had personal clothes there. Most of the personal clothes were locked away in cupboards within the sleeping area and only brought out at certain times. Other than the clothes, children didn't have many personal possessions. They didn't have toys or cuddly toys. If there was anything personal, there would be what was called the 'lock up'. They'd be kept under lock and key. There would be some personal things and some clothing there, anything that needed to be locked away.

86. I'm struggling to remember any of the children having any personal possessions. Within the ward, it was pretty bare. There were a few bits and pieces kicking about, but nothing personal. Toys would very easily get broken or misappropriated. It wasn't an environment where personal possessions could be maintained at all. They didn't get pocket money. There would be sweets now and again, but I don't remember too much of that at all. There would be sweets to help the medicine go down.

Visitors

87. The visiting arrangements were Saturday and Wednesday afternoons. How much leeway there was would depend on the ward itself. Most of the wards liked the routine where they could compartmentalise the visits and be sure that was when they were happening. They could then dress the children nicely. Families could take children out if they wanted to. They weren't discouraged from visiting. It was very individual. Some were totally dedicated. In the hospital block, some of the patients were still in their teens. You looked back over the visiting book and every visitor would be entered in. You could see that some patients were visited twice a week for twelve years. Their parents never missed a week. Some might get one visit from year to year. As well as parents, extended family would visit the children as well. I think there was sometimes

some manoeuvring about visits being withdrawn as a punishment. I suspect that was sometimes used as a threat or a punishment. I don't think that it was something that was widely used or rife.

88. I never saw social workers visits patients on the adult wards. On the children's wards, they came into the education building and the playgroup environment. I saw a fair bit of the social workers when I worked at the playgroup. They were still in contact with the home and the family of kids who had come in recently. The social workers were placed at Lennox Castle so they were designated Lennox Castle social workers.

89. There was a playgroup committee, but it was slightly after my time. They were local volunteers who helped out with the playgroup. I think it broke off and they ran a separate voluntary playgroup, but that was after I left. The volunteers would have been supervised by staff.

Supervision/appraisals/checks

90. Each student would go into a ward for a couple of months, then there would be a discussion and an appraisal. The student would be marked on various aspects which they needed to perform to get their nursing qualification. I don't know how unqualified staff were given appraisals or whether that was done routinely. I would imagine that there would have been something, but it might have been quite tokenistic. Qualified nurses had an annual appraisal, but I wasn't there long enough to get that.

91. I don't think there was much differentiation between children and adults amongst the staff. It was all part of the same thing, apart from the educational input. In fact, when I worked within the children's ward there was certainly a perception that if there was money available for any facilities then it wouldn't go to the kids. They weren't a priority. That was certainly expressed to us on several occasions. There was no specific system of checking by the hospital about the adequate care of children. The hospital was set up with a structure that was supposed to provide adequate care. There were responsibilities, reporting, official documents and day to day routine. I suppose these

were all deemed to be tick boxes. As far as I'm aware, there was nothing geared towards the particular needs of children.

92. Very few of the children that I worked with were verbal. There were maybe three verbal children within the environment that I worked. It was slightly different in the other children's ward, but there was no named individual or person to advocate for them or anything like that. The ward sister or charge nurse would be the ultimate person within the environment.

93. There were disciplinary procedures for staff. There would be verbal warnings and ultimately people could be fired. It was more an informal type of discipline rather than by the book. The whole thing was imbued with relationships, both family relationships and relationships of a small community. That was a very big aspect of it. That's not to say that disciplinary procedures weren't in place and followed, but the informal type of discipline was much more common. I think that made it more difficult to deal with certain poor practices. I found the whole place warmly enveloping initially. It was as if somebody devised a programme and pre-thought it all. It brings you in and it makes you feel comfortable and welcome and fascinated and then slowly the revelation of the practices go on. By that time, you're in there and it's so much more difficult to challenge.

94. When I was there, one person was fired for physically abusing a patient. I don't know of any other person who was formally reprimanded. The person who was dismissed punched and kicked an adult patient and severely beat him up. The patient was injured. It was a major occurrence. There was informal punishment by staff and that happened regularly.

95. I did feel able to challenge some of the behaviours and practices. I was able to challenge them on a one-to-one basis rather than by officially reporting somebody. If I saw a student nurse slapping a patient, which did happen, I'd take them aside. I was a student nurse as well. I told them they couldn't do that and it was against the law. Secondly, I would try and have a rational conversation with them and tell them they wouldn't last long there. There were certain physical punishments that were part of

every ward's routine. There were lots of instances of similar conduct that I had to challenge. Within the Adair Ward, it was quite different because there was smacking. When children were smacked, they were generally smacked across the wrists, smacked across the backside and occasionally smacked across the face. Implements were not used. Within the Leslie Cox Ward, I've heard that no child could have a finger laid on them because of the regime that was laid down by the charge nurse there. It was quite different.

96. When I was a student in the Adair Ward, I observed some heavy-handed people. When I qualified and became a staff nurse there, I spoke to all the staff and told them that when I was in charge nobody would be smacked. There was a great outcry. The rationale was, "I smack my own weans. If they do something wrong, they need smacked. They need to understand." It was one of the few times that I tried to have a rational conversation about smacking. I would say to them that they might smack a patient for doing that, along comes another nurse who smacks the same patient for doing something different, the next shift comes on and he smacks the patient, then the night shift comes on. This patient might be getting smacked twelve times by twelve different people. I tried to open things up and let it breathe. I would say to people that if their kid was getting smacked, he didn't get smacked twelve times by twelve different people roundabout Kirkintilloch. That was the only time that I ever tried to be rational and have that conversation rather than just say, "You don't do that." It worked a bit, but I'm sure it still happened behind my back because that was what happened.

97. I think that most people, students or qualified staff, felt strongly that the kids were where things could happen and things could change in the hospital. We felt that things could improve and develop for the children if they were given the right support. The hospital didn't seem to feel like that at all. I took the kids out quite a lot to Glasgow and tried to socialise them. Other staff did that as well. Within the hospital, you were up against it but you could take them out to another environment, take them to the circus, take them to see the Christmas lights and things like that. You could try and lead them into normal circumstances and take them away from Lennox Castle, which didn't seem to be encouraging anything very progressive within the kids wards. Those trips didn't feel supported by the hospital. They certainly weren't supported by money.

External monitoring

98. There was an annual inspection, which was a government publication. It went back to the nineteenth century in all similar institutions. I don't think any of the staff were ever aware of that, but it would be completed by the physician superintendent in consultation with a visiting medical group. They would assess how the year had gone and look back on the reporting of the year in terms of incidents and ins and outs. That was the official reportage. The nursing staff weren't involved in those inspections. To my knowledge and experience, the inspectors didn't come to speak to the nurses or the children on the wards. If there were any recommendations for change, that wasn't something that the staff would have been aware of.

99. The minister and the priest might come onto the ward. There were some reporters who were welcomed in on certain occasions. There was an ITV documentary in the late 1970s, early 1980s highlighting various aspects. Apart from that, I wasn't aware of anything formal going on.

Running away

100. I can certainly remember one child who liked to run away, but he really just liked to run. In the adult wards, 90% were informal patients, which meant they could do whatever they liked. Legally, they could go home or they could go into Glasgow. If the patient was informal, then it was their prerogative to walk out of the hospital if they wanted to. There were no gates. You could walk where you wanted, down into the town or get a bus into Glasgow if you were able to negotiate that. Many did that. There was a parole card system where the charge nurse would sign off a trip to Glasgow.

101. The other 10% of patients were there through court orders. They had to be kept at the hospital. The majority could do what they wanted, but if somebody went missing they would be a 'runaway' and attempts would be made to locate them. In the old days, the nurses would go out with the police and go to try and bring them back.

102. I don't have first-hand knowledge of how the staff responded to somebody running away. My only knowledge of that is through interviews. There were a couple who ran away and were formal patients. The hospital was duty bound to track them and they were brought back. Nothing happened to them. However, I do remember one person in particular who did get away and disappeared. He was found a year later up in the forestry, dead. It was a huge swathe of forestry to get over to Glasgow by a certain route. There was usually a concern about what had happened to somebody who ran away rather than a jailor type attitude.

103. Historically, there would be a regime for escapees of white moleskins and what was called 'the 6 o'clock stint'. They'd go to work with their white moleskins on, come back at 6:00 pm and go to bed. That would be the punishment for runaways, but that was historical and I didn't see that.

Restraint

104. Sedatives were sometimes administered informally in order to restrain a person. I'm not suggesting that was done a huge amount but I'm sure that did sometimes happen. I think it was used in the adult wards, but I don't think I saw any over-sedation or sedation that was outside the prescribed sedation in the children's wards. Certainly if you reviewed some of the medication, a pharmacist might have said that some of the medication was a bit unnecessary or heavy. However, I don't think that people were saying, "Oh well, we'll give them a wee bit more of this because they're providing a challenge."

105. There were several patients who were physically restrained and routinely tied to chairs. I can recall a patient on an open ward who was tied to chair. It was done to stop him running out and injuring himself, which he did. That was the rationale. It was roundabout self-harm or violence to other patients. It didn't happen to many patients, but there were a few. I never saw it being used on any of the kids.

106. There was one man and one woman that I can remember. The woman used to [redacted] self-harm in that

way. I believe that sometimes they restrained her by tying her up, but I never witnessed that. The man [redacted] They made him wear special gloves so he wasn't able to do that. I witnessed that first-hand. I believe that at some points they might have tied his arms to a chair to try and control that as well. I do believe that was recognised and sanctioned by the medical staff. I never witnessed it being used as a punishment.

107. Although the intentions were skewed, the rationale was for the good of the patient. Quite often, these things are for the peace and comfort of the staff. I don't think it was ever appropriate. There's always an alternative to sitting someone in a chair and tying them up. There were so many things tried and done, using different materials and padding. It was a whole rigmarole about the right and kindest and best way to do it going on, which sounds ridiculous. Whilst restraining someone and tying them up, there was a care and a feeling for the individual within that. I think it was misplaced and that it was terrible, but in my experience it was never used as a punishment.

108. Restraint might also be used when a patient was fighting or attacking somebody or attacking the fabric of the wards. Breaking windows was a very common but bizarre thing. I think it was because of frustration and not being able to express that frustration to staff. A lot of patients would [redacted] injure themselves. It was a common way both to self-harm but also to get back at the staff. I wasn't aware of any written guidance on the use of restraint. I only became aware of any kind of restraint techniques or protocols after I'd left Lennox Castle.

Discipline

109. The types of behaviour that might attract a punishment were fighting, attacking staff, breaking windows, running away, anything that was considered to be cheeky to the staff. I interviewed [redacted] on two occasions as part of the material for the Open University. I think the interviews took place in 1996 and 2006. She was a very feisty woman. She had been at Lennox Castle from a toddler right the way through. Hers was a very illuminating case study. At one point, I worked on her ward where

there were a lot of teenage girls who were challenging to manage. They had been placed in the totally wrong environment.

110. People were given chores as punishment, but I never witnessed that. It happened more on the women's side of the hospital. Until the late 1960s, the patients had looked after the wards. They polished the brasses, swept and buffed the floor until the hospital started to employ domestic staff in the late 1960s, early 1970s. The domestics then did that kind of work, but it continued through in the women's side that women would do the buffing of the wooden floors and things as a punishment.

111. There was certainly a reported regime of bread and milk in the old days for people who had escaped. They'd be put to bed at 6:00 pm and they'd only have bread and milk. I never witnessed that personally, but when I interviewed older members of staff they did report that as happening. I can't remember directly witnessing or even hearing about withholding food in my time at the hospital, either in the adult wards or the kids wards. I do remember that, as part of behaviour modification, there were some reward schemes. If you behaved, you got sweets and that kind of thing. There was a withholding of rewards for negative behaviour.

112. Hut N was the men's punishment ward when I was at Lennox Castle. It was a punishment ward and a secure unit, or more secure than anywhere else. If you caused a disturbance, if you were involved in a fight, if you escaped then it would be Hut N for you. The staff who were in there were perhaps less tolerant and the regime was less tolerant than some of the other wards. There would be no nonsense, whereas some of the wards were quite benign and relaxed. It was a stricter day to day regime and there were more staff and more observation by staff. I don't know if there was a similar punishment ward for the women.

113. There were lots of insidious things, like preying on people's weaknesses. There would be members of staff who might know that a certain patient's weak point might be a story about their mother. They would be able to say a few words and press a few buttons in that way. There was quite a lot of that. I don't know how you describe that, but it's not so much punishment. It was probably in response to negative behaviour,

to poke back at somebody or as a warning. It was a very individual staff, individual patient thing and not something you could describe as part of the hospital as a whole.

114. To my knowledge, the hospital didn't have a policy for sanctions because a lot of it was done informally, under the radar and not through the books. You had to manage your ward environment and that might have required you to be tough and heavy-handed. It's a long number of years that's being covered. I often need to differentiate between what I saw and what I heard and what I heard third hand. At certain points in the hospital's life, you had to be tough to manage a ward of seventy men. A lot of staff were tough, a lot of them were too tough and a lot of them were tough past the time when they needed to be tough. When the hospital changed into an environment that looked after people with multiple needs, complex mental and physical difficulties, a lot of them were still stuck in the past where they were hard men in a hospital environment. They would slap and sometimes punch. They would kick somebody up the backside.

115. In the Adair Ward, children were smacked across the wrists, the backside and occasionally across the face. It was no more than individual slaps. I mentioned that I had conversations about slapping with members of staff. It wasn't just with an individual. It was with many individuals. However, I think that in their own way, the vast majority of the staff cared quite a lot for the kids.

Record-keeping

116. Admissions records would be part of the medical records, which were held centrally and not kept on the wards. Everybody knew what sort of information went into nurses' files. You could look back and see what was there. There was a daily report book, where the nurse in charge would record the number of patients in the ward, any patients that were out and any incident of note towards the end of shift. They would sign it and tear it off. The top copy would be taken over to the nursing administration and the book would be kept on the ward. That happened three times a day. There were also nurses' notes, which in certain instances might only be filled in once a year.

117. There were punishment books and escape books which went up to 1973 or 1974. While I've seen them, I wasn't involved in filling anything in. The punishment books and escape books were rather large and formal. After that, punishments were recorded in the daily report book in the nurses' notes. Use of restraint wasn't recorded, unless it was formally prescribed use of sedatives. You'd put someone's name in the daily report book and record that the sedative had been administered. If it wasn't done formally then obviously it wasn't recorded. Physical restraint wasn't recorded, unless it was something like, "So and so seen fighting with somebody. Staff had to intervene and physically restrain." There might be something like that.

118. If somebody was perhaps being targeted as moving on, moving out or something had come up in a community setting then there might be a case conference. That was just starting to come in. Social work, medical and nursing staff might attend the case conference around that and there would be a review of what we would do to equip somebody to move on. Other than that, records weren't reviewed on a monitoring basis to check what was going on in the wards.

119. When the hospital closed, the records should have been passed to the health board but I know that they weren't. There are tales of black bags being discovered and some were rescued, some were not. I wasn't there at the time so I don't know what happened to the records that were rescued. I know that anecdotally a lot of the records, including lots of patient records, that should have been transferred were found not to be. Many were found on the hospital grounds, ready for disposal.

Abuse at Lennox Castle

120. I saw kids being slapped, occasionally on the face, quite often on the wrist and sometimes on the bottom. Smacking of children was quite frequent until I was in a position to say that it shouldn't be. It was every day. It wouldn't be the same child every day, but every day one of the kids would be smacked for a certain thing. The situation then arose where the big girls, who were older patients at Lennox Castle, would take it upon themselves to smack children as well because that was what they observed to

be the right thing to do. To my knowledge, no child ever needed medical treatment as a result of physical abuse by the staff. I never saw any child being punched. I didn't see children being restrained or tied up. I did see a couple of adults being punched, although that wasn't frequent. I didn't witness any other overt physical abuse by staff, although I have already mentioned that one member of staff was dismissed after he beat up an adult patient. That was considered to be a major occurrence.

121. I'm not condoning anything, but the 1950s, 60s and 70s were much more violent times. On the streets of Lennoxtown and in people's houses, there was a higher level of physical abuse within families and between peers. People took that to their work and behaved like that in inappropriate settings. There was also undoubtedly an element that people could get away with it because they were dealing with people with a learning disability, who they would perceive not to be able to retaliate them personally or retaliate against the system that was pressing down upon them very heavily. There were some sadistic individuals.

122. I understand that a *Daily Record* article published in 2013 suggested that some patients were used as entertainment, women were made to strip naked while staff laughed at them and men made to perform sexual acts on each other for the amusement of staff. I absolutely wasn't aware of that anecdotally, since or historically. I've never heard anything about that.

123. I can recall fire hoses that were wound round the walls on all the corridors. I never saw it myself, but I know that sometimes a member of staff would turn one on for a laugh. Quite often, they did it to another member of staff. I can see how it might happen that a patient would be hosed as well, but I never witnessed that or knew of that happening.

124. I can think of hundreds of interactions that I witnessed that might be considered to be emotional abuse. Degrees of that were frequent, including in the children's wards. It was probably less in the children's wards because there was a different feeling around the kids. There were certainly things like fat-shaming while some of the kids were in the bath. I can remember a girl who had Down's Syndrome and she was quite fat. I

can remember several members of staff used to be greatly amused that the water would stay behind her when they let the bath water out. They were shaming her, really.

125. There was often a co-dependency amongst patients at Lennox Castle, which meant that there could be abuse going both ways. I can remember one guy in his forties, who I knew. He was looking after another guy. They'd been in the Leslie Cox Ward together as twelve year olds. He had thirty years of continually caring for this person, who was very problematic for staff. He had a one-to-one relationship with that person. Sometimes, the caring one lost his temper and was a bit abusive. It was also abusive to him because that was his task in life, merely to look after this patient who the staff found problematic. There were many, many instances of that happening and going on and on for decades.

126. Within one of the first wards that I worked on as a student nurse, there were quite a few young guys aged from sixteen to twenty. They were very physically disabled. There was an older patient who used to help out by putting them to bed and washing them. I happened to look in the ward and discovered him masturbating one of the physically disabled patients. I reported this to the charge nurse and the response was, "Oh aye, that's KYE" It was never taken any further. I suspect that was why the older patient liked to do the washing or help the staff. It would vary whether those with a physical disability were aware of that kind of conduct. Some would have some awareness and some wouldn't. I suspect there was a fair bit of that kind of thing going on in other wards.

127. I felt outraged that I had reported it and it wasn't taken any further. I felt morally outraged, but I also felt slightly sorry for this old guy. He didn't have much speech and he was in his sixties. I don't know whether that was how he got some kind of physical pleasure. Perhaps for guys who have multiple disabilities it might be one wee bit of physical pleasure in their lives, albeit with no consent at all. There was a movement in the 1980s about sexuality and learning disability. There were conferences about how nursing staff could help patients with a learning disability and physical disability express their sexuality and how they could help them physically, which seems absolutely bizarre now. It was a thing that was talked about openly, whether nurses

could help patients masturbate. It wasn't black and white. Generally I felt that I'd tried to do something about what I had seen, but there appeared to be nothing happening.

128. I wasn't aware of any other instances of patients harming other patients sexually. There were lots of fights between patients, but they were out in the open fights. I can remember someone breaking a chair over someone else's head and fracturing his jaw, but I didn't know of anything that wasn't overt like that.

Reporting of abuse

129. I don't know of any of my peers who ever reported anything at all formally. There were probably some people who would have a word with another staff member, but in terms of official whistle-blowing that didn't happen at all to my knowledge. When I worked at Lennox Castle as a qualified nurse, nothing was ever reported to me.

130. There was a defensiveness on the part of staff, that outsiders didn't understand their work at Lennox Castle. There was also a lack of representation and voice for nursing staff. They were victims too of established practices, difficult conditions and a powerful medical presence. There was a lack of any feeling of control of their destiny or the destiny of any of the patients that they looked after. It felt as if things were set in stone and the outside world was against them. There was little that they could do to change. The medical staff were, if not their enemy, certainly an opposing force in many ways.

Police investigations/criminal proceedings

131. I've never provided a formal statement about my experiences at Lennox Castle. The police used to bring back people who had ran away from the hospital. They were also involved with the case when a member of the nursing staff was sacked for assaulting a patient. Apart from that, I can't recall them being involved at all. I am aware of three accidental deaths at Lennox Castle. There was a woman who died after being scalded in the bath. There was also one patient who was physically restrained and I believe

was strangled. I think that was in the late 1970s. I think I was at the hospital at the time that happened. In the late 1980s, I believe there was a man who accidentally set himself on fire and died within the ward. These deaths were formally investigated and Fatal Accident Inquiries were held.

Leaving Lennox Castle and roles with children in other hospitals

132. After I qualified at Lennox Castle, I went on to do a qualification in general nursing. In the early 1980s, I had a training role at Gogarburn Hospital so I didn't have direct responsibility for the care of children. I had passing interaction with children, but I wasn't in a care role. There were similar dynamics in Gogarburn as there were in Lennox Castle. They didn't have as many young children there. They did have quite a few adolescents. It was a very similar set up in many ways, although they had quite a different nursing team. There were many more younger nurses rather than the elderly nurses I had encountered at Lennox Castle. I was aware of practices at Gogarburn that I thought were abusive. I whistle-blew there and ended up leaving. That was my final straw with the Health Service. The reason I whistle-blew isn't relevant to the subject of the Inquiry.

Academic work in relation to Lennox Castle

133. At an undergraduate level, I did some recordings of two people who had worked at Lennox Castle. This was in Scottish ethnology where people were celebrating rural and Gaelic culture quite a lot and recording oral histories of people who were digging peat bogs in Ullapool or castrating sheep in Shetland. I wanted to explore what was my background, which was the industrial West of Scotland. I also did some more roundabout general nursing, looking at nursing in hospitals as communities and the folklore, narratives and practices that made up these communities. I carried that on into postgraduate work, looking at learning disabilities throughout the centuries. I brought it up to date, interviewing a whole range of people. I interviewed former

residents, patients, doctors and ancillary staff. Those interviews are held by the School of Scottish Studies archives.

134. When I left university, I did commissioned work for the Open University and its course on 'Understanding Health and Social Care'. I carried out more filmed interviews and written work, focusing on a couple of individuals. I interviewed [redacted] who had been in Lennox Castle since she was a toddler. I think I have a photograph of her when she was about six years old. I don't think I interviewed anybody else who had gone right through to adulthood from that early age.

135. Another piece of work was an exhibition commissioned by the hospital itself to celebrate the closure of the hospital. It involved more interviews within the hospital setting and in people's housing. There was photographic and film material as well. The Health Board pulled the funding for a book I was planning to write about Lennox Castle. Instead, there was a pamphlet publication accompanying the exhibition. The film was part of the exhibition. It was shown at the launch of the exhibition and it was available on DVD. It's called 'The Human History of an Institution'. More recently, I took part in a podcast for BBC Radio 4's *History on the Edge,* broadcast in August 2023. In 2022, I also advised on a theatre production at the Lyceum, *Castle Lennox*, written by Linda McLean.

136. As part of my research, I viewed some archival documentary evidence, including a visitor's book, a misconduct book for male patients and a register of escapees. That came from the local records office at Lennox Castle. They held those records within the hospital, but I don't know where those records went when the hospital closed. I have some photographic copies of things like my birth entry.

137. I interviewed residents who had moved to the community unit and some residents who were still in Lennox Castle. All but one resident knew that I'd worked there. The one who didn't know was the one who gave the most free and lurid criticism of the nurses. I don't have that interview any more. It was a very early interview, transferred onto Betamax. The resident's criticisms were that the staff were cruel, pushed and ordered patients about and never gave them their tobacco rations. He had valid reasons to feel

like that because he didn't want to be there and he was forced to be there. In their interviews, a lot of the criticisms from residents were about the overall strictness of the regime, "They got you up at 6, they made you stand by your bed, they counted you in and out," and that kind of thing. It was quite often a criticism of the institution and the environment rather than a criticism of individuals. You got as many if not more people saying that someone was "a good staff".

138. I did have a choice when it came to who I interviewed for my academic work. Initially, I interviewed people that I knew. They were also people that I knew would be open and willing to talk to me because I'd known them for quite a long time. As it progressed, I interviewed people that I didn't know. It was a case of phoning them up or knocking on the door and telling them who I was and what I was trying to do. On the whole, people were absolutely delighted to do it and in some way be recognised. There were people who had worked there for forty years, felt that Lennox Castle had a terrible reputation and wanted to tell their story. It was hearing about different people and trying to make a cross representation of types of people, types of staff, doctors, nurses and residents as well.

139. I didn't want to dwell on aspects of abuse and there were areas that I deliberately stayed away from. The best practice in oral history is that you have somebody assign their copyright to the project. In interviewing, I am aware that first of all I have to ask somebody to assign what they tell me and relinquish their ownership of that in order that I may use it. There is an inbuilt thing there that if I'm trying to in anyway get them to tell me things that may bring discredit or even legal redress to them, I'm not doing them much of a favour. It's probably not as coherent as that at the time and my interviewing changes as I go along. There was also an element of protecting them from themselves in some way.

140. As a younger man, I was very well aware of what the current views were about Lennox Castle, about care and about how you treat people. I might have been interviewing someone in their eighties who was brought up in the 1920s. Things had changed since then. A tiny example would be someone saying, "There were cripples and you just loved the cripples." I was trying to make this available to a wider audience so that they

might understand. There were all these things flying around. There were also lots of familial things.

141. I was trying to manage all these conflicting things, protect them from themselves and give some kind of overall picture of the great scope of it. It was also about trying to admit that it was obvious the people who lived in Lennox Castle as patients were victims. They were victims of a terrible period of institutional and care history. They were abused by the system and they were abused by individuals. I think that's obvious for anybody with any care, compassion or insight to see. There are lots of people who were involved in that care who were also slightly victims, mostly not, but also had their story to tell. They were a huge part of a complex situation.

Lessons to be learned

142. I advised on a play at the Lyceum last year called 'Castle Lennox'. Linda McLean, who wrote the play, was the niece of a resident at Lennox Castle. The play featured a woman as its main character. It did well to bring out the motivations of wider society and people's relatives. What tends to happen is that people say, "Lennox Castle is a terrible place, look at how cruel it is, look at what happens." There is a wider societal responsibility about why people ended up there and the motivations of those who had relatives there.

143. We need to learn the lessons of the past, as every generation fails to do. ELCAP provide housing for people with learning disabilities in East Lothian. Their big focus is that everybody should have their own tenancy. There was a lot of that going on in the early 2000s. ELCAP was a bright and shining example and hugely expensive. I felt that the pendulum swung towards providing the best possible care for people with learning disabilities. It was recognised what a terrible time they'd had for so long. Lots of people had their own tenancies, but were very expensive to support. What's swinging back is whether society can afford this level of care. Individual support is being taken away and replaced with electronic cameras and beepers and buzzers.

144. In lots of care settings, you're putting care staff in very vulnerable situations for them and the person they're caring for. They're working one-to-one in an enclosed environment. It has implications for the staff because they don't work with supportive fellow colleagues. I've described how working with colleagues can be an insidious, negative thing, but it's also quite often a necessary thing to have the support of a peer group roundabout you as you deal with very challenging individuals and people. If you don't have that and you're working one-to-one and you're being challenged, that's a powder keg, particularly if people are being paid minimum wages.

145. I did a project with Garvald Edinburgh about their history. They were set up as a Rudolf Steiner based model which came over from Germany. They have workshops in Gorgie. It was the most refreshing place for supporting people with learning disabilities that I've ever seen. All the focus was on art and craft, they make bread, they paint, they do puppet shows, they make stained glass. All the staff are not recruited because of their care credentials. They're recruited because of what they can do with their hands. It imbues the whole organisation. Subsequently, they've got a different attitude. They bring out the artistic side of people with learning disabilities. That also transfers into the residential side of things as well.

146. It's the individual and the individual's motivations, together with the training, together with the culture and environment that matter when it comes to the impact someone has on caring. It's not always carers that are best to care.

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

Signed..... [redacted] .....

Dated..... 13 March 2024 .....