Scottish Child Abuse Inquiry

Witness Statement of

Rhona MORRISON

Support person present: No.

1. My name is Rhona Anne Morrison. My date of birth is [redacted] 1963. My contact details are known to the Inquiry.

Qualifications/work history

2. I am a qualified doctor and I have an MBCHB from Glasgow University. I also have a diploma in forensic medicine. I am a member of the Royal College of Psychiatrists. I specialised in forensic psychiatry, working with offenders with mental disorders.

3. I finished my degree at Glasgow in University in 1985. As a medical student, I did a placement in Merchiston Hospital, just outside Paisley, which was for people with learning disabilities. I then went to the Southern General Hospital to do medicine and surgery until 1986. After that, I went straight into psychiatry at Dykebar Hospital in Paisley. I was there for three years before going to the Douglas Inch Centre in Glasgow, which was a forensic psychiatry centre. I was a senior registrar there for six years.

4. I left the Douglas Inch Centre and became a consultant at NHS Forth Valley in 1995. I remained there until I retired in 2018, but my job altered quite a bit during that time. Initially, I had some general psychiatric and intensive psychiatric care responsibilities as well as Cornton Vale Prison. Over the course of my career as a consultant, I became Associate Medical Director for the whole mental health service in Forth Valley.

That job had quite a large management component. During that time, I continued to work in Cornton Vale Prison. I'm not sure of the exact dates, but it was on and off for a protracted period of about eighteen years. I also worked at Polmont Young Offenders Institution and Glenochil Prison. I gave up my prison sessions because I had too many managerial commitments, but I was responsible for all the psychiatrists working in the three national prisons in our area.

5. The main clinical part of my job was that I started the forensic community mental health service in Forth Valley. It was the first proper multi-disciplinary team in Scotland. At the Douglas Inch Centre, it was pretty much psychiatrists and psychologists and a couple of social workers often working independently of each other. It didn't have a multi-disciplinary team approach. We set up the first such service and I worked in that until I retired. That was a big clinical commitment.

6. I can provide the Inquiry with observations based on my experience but I am not able to remember individual cases. Most of my work involved adult patients, although I did child and adolescent mental health for six months as part of my psychiatric training. I did that in Paisley, but you don't see a huge number of patients as a trainee. I also worked at the school attached to the Douglas Inch Centre and at St. Mary's, Kenmure secure school whilst I was a senior registrar.

Work at the Douglas Inch Centre, Glasgow

7. I started at the Douglas Inch Centre in 1989. It was a service for Greater Glasgow. The main method of referral was from the courts for reports, although we sometimes received GP referrals. There were consultant forensic psychiatrists, senior registrars, forensic psychologists and social workers, as well as administrative staff.

8. During my time at the Douglas Inch Centre, I changed training placements every six months. I chose a different topic to focus on every six months. Although I had an ongoing commitment to the State Hospital at Carstairs and the Intensive Psychiatric Units within Glasgow hospitals, I worked in different places every day. Over the course

of each six months, I was probably in four or five different places. It was quite complicated. I worked in many prisons when I was a trainee at the Douglas Inch Centre. We had to take our share of all court reports for rapes, murder inquiries and other criminal cases. In my training, I was trying to tick off certain things. Every six months, I would have a particular focus. This included young people, sex offenders, females, males, people with a learning disability, psychotherapy cases involving trauma and addictions. I wanted to build up my expertise.

9. The Douglas Inch Centre had a school underneath it for young people who were on the verge of going into care or who were starting to offend. I worked in the school and also at St. Mary's Kenmure. I tended to do court reports for young people at that point. I then focused on female offenders in the clinic but also at Cornton Vale and the State Hospital. When I worked with males, they were in Barlinnie, Barlinnie Special Unit and Carstairs. I tended to focus on different things. I worked in the Alcohol Addictions Unit at Low Moss Prison and with young offenders in Longriggend. I also worked at the Mental Welfare Commission and then at Parkhead in Glasgow, where I did a psychotherapy clinic for sexual abuse.

10. As a senior registrar, I also worked at Lennox Castle Hospital. When I was younger, I had gone there on a weekly basis to visit my sister, who was a resident in the hospital ward there. I also did summer jobs there as a nursing assistant when I was at university. I went back as a senior registrar in forensic psychiatry to do some additional training there. I also went to New Zealand and did learning disabilities psychiatry for a month during my training. I did some research into blood pressure in Down's Syndrome, working in adult training centres and hospitals, which involved following the same people up after ten years.

11. I originally wanted to do learning disabilities psychiatry because of my sister. There was more of a focus on that earlier on in my career. They were hoping to create a job for me in Glasgow based on that, but the funding didn't come through, so I ended up doing something else. There continued to be a willingness from me to see people who had learning disabilities even though my service wasn't a learning disabilities service. I felt comfortable dealing with that client group. I was working with offenders for most

of my career. Some of them would have a learning disability but more often than not, they weren't at the severe or profound end of learning disability.

Work with sex offenders with learning disabilities

12. At the Douglas Inch Centre, we ran a group for sex offenders with learning disabilities. The majority of those offenders would have been over the age of eighteen, but I don't recall there necessarily being a lower age limit. The group was borne out of the fact that I had an interest in that area, so I would see people for court reports. My overwhelming impression was that there was a lack of knowledge about what was appropriate behaviour or not. It seemed to me that people with learning disabilities were more likely to get into trouble for this type of offending because they didn't really know what was right. Not all had deviant sexual fantasies.

13. Part of my learning was that some offenders might have deviant sexual fantasies, but actually some may have been abused themselves. More often than not, parents had been over-protective of their offspring. They felt that they had enough problems and should be protected from engaging in sexual behaviour. However, they had hormones and sexual drive like everybody else. They had often not been given sexual education and therefore sometimes expressed their normal sexual drive in an inappropriate manner with someone who might be vulnerable, as they were functioning at a similar intellectual level.

14. What we ran was not based on any research-based programme. Myself and another senior registrar decided to work with some of the people who had been attending the clinic. There were similarities and we felt that it would do no harm to do some education about what was appropriate in terms of sexual/social behaviour. It was an outpatient clinic. People would come along voluntarily and weren't compelled to come.

School at Douglas Inch Centre

15. The school underneath the Douglas Inch Centre was for young people who were on the verge of going into care or were starting to offend. It was a day school and I think

they all attended part-time placements. The children came from all over the city. They were on the verge of going into children's homes and residential schools. They were on the fringes of drugs, alcohol and offending. Some were school refusers. The part-time placement was their last chance saloon.

16. The main contact I had with children as a senior registrar was when I did a six month placement in the school. I had done training in cognitive and behavioural skills for high risk recidivists. It assumed that people don't have the basic cognitive skills to think their way out of a problem. Often, work was done with people who were already in custody. They were already offending and going down a particular route. My thinking was that surely prevention was better than cure. I thought that we should be teaching kids who were on the verge of going into custody a skill set, so they could make choices and have alternatives. I therefore decided to run the same programme with the school children.

17. We couldn't select children for the programme. We had to take the whole class. Some could read, some couldn't. Some were shy, some were more outspoken. It was a mixed bag. I promised the children that I'd never ask them to stand up and write something if they couldn't do it, but that I expected them all to participate. The teacher sat in. If I needed for a volunteer for anything, I would look to the teacher who would suggest someone so nobody was put in a position where they were asked to complete a task which they were unable to do.

18. We were trying to teach the children to stop and think before they acted, to think about the long and short-term consequences for themselves and others, to have a plan B. We did lots of exercises. The teachers were observing and didn't take part, but it was nice to hear that they noticed a difference in the pupil's interaction in the classroom. If the teacher had made a promise and didn't follow up on it, the children would follow up on it appropriately. They were actually using some of the skills we had taught them in the classroom. The hope was that the learning would generalise into situations which were more risky for them. It was quite an interesting project.

19. My learning has been that if you get people early and give them the skills, then they've got a chance in life. I think that's the same with abuse. There are lots of people who have been abused who go on to do well and there are those who don't. When you speak to people who have done well, they often report that one teacher or one social worker showed an interest, believed in them and showed them a different path. If you teach people the skills to think their way out of a situation, then they have a chance. That was my thinking when I worked with the school children. I ran the basic parts of the same programme for young offenders when I was in Polmont as a trainee. I wanted to give them some extra skills.

Learning disability research/Royal National Hospital, Larbert

20. I carried out research into blood pressure and Down's Syndrome. I was comparing two populations, those with Down's Syndrome to those with learning disabilities (but not Downs). I was also comparing those two populations in a hospital environment to those in adult training centres within the community. There had been a suggestion that people's blood pressure was affected by their environment. Blood pressure usually rises with age. There had been some research to suggest that the blood pressure of people with schizophrenia did not rise at the same level. Researchers were arguing that people with schizophrenia were in care so institutionalisation was protecting them from stress.

21. The research mentioned people with Down's Syndrome, whose blood pressure was even lower. Researchers were arguing that they were protected in their environment too I had been visiting my sister in these environments my whole life. The people with Down's Syndrome were more active than a lot of the other people in those environments, handing out the mail and things like that. It didn't fit and it didn't seem right to me. If people with Down's Syndrome had lower blood pressure, I thought it must be for some other reason. I therefore tried to compare people with Down's Syndrome to other people with learning difficulties in two different environments. There should be more stress in the community compared within an institution. However, the blood pressure of people with Down's Syndrome failed to rise with age or in different

environments, even when I followed them up after ten years. I concluded that it was something to do with Down's Syndrome rather than stress or environment.

22. In the course of my learning disability research into blood pressure and Down's Syndrome, I used patients from the Royal National Hospital in Larbert. The only time I spent there was to go in on three occasions and take the blood pressure of the patients involved in my research. Ten years later, I went back three times and took everyone's blood pressure again. I went onto a ward, saw people and went back out again. Nothing stands out in my memory as being particularly good or particularly bad about the Royal National Hospital.

23. In the course of my career, I didn't come across many people with learning disabilities who had been in care. I certainly met people in adult training centres with learning disabilities when I was doing my research. My perception was that they were well cared for and that services were trying to work with them to make them achieve their best and have a good quality of life.

New Zealand learning disability services

24. During my training, I went to Dunedin, New Zealand and looked at learning disability services there. That was quite interesting. They were doing smaller projects but utilising people's skill sets as best they could. A good example was that they set up community units for people with varying levels of disability. They were in the same unit and staff were there permanently. They ran a service doing laundry for older people in the community. Some people would have to go on the bus to pick up the laundry. They'd be using their skills to pay the bus fare, get on the bus and talk to people. Some people might not have been verbal so they'd split up the clothes into whites and colours. Someone might be able to read the labels and someone could work the machine. They all had a role within their own skill set. Rather than receiving care all the time they were actually caring for somebody else. It gave them a sense of self-worth and they were learning skills.

25. As a small example, I thought it was a really good example of what we could be doing quite easily. The people in that community had come from hospital settings. I did visit their hospitals when I was there, which were not dislike ours. I thought they were further ahead with de-institutionalisation and re-integration into the community. They weren't just putting people somewhere different and the problems were the same. They could actually improve their quality of life and their skill set.

State Hospital, Carstairs

26. I would work at Carstairs about once a week for six years while I was a senior registrar. My recollection is that there weren't many young people there at that time. I don't remember them being there. There were very few females there and ultimately none. The numbers of women were getting so small that they couldn't provide a service and they were moved to England.

St. Mary's School, Kenmure

27. I worked at St. Mary's once a week for a six month period of my training. I was focusing on young offenders at that point. I went there to see another cohort of young offenders and the sorts of issues that they had. My initial remit was to run an outpatient clinic at the school and just deal with issues as they came up, whether the young people were depressed, suicidal or whatever. I think I only did that for two weeks. I was walking through the place and I was struck by some of the behaviours that were being tolerated by staff and their response to it. It just didn't feel right. I can't remember the specific conversation, but I remember something about how staff responded to self-harming. It didn't feel like staff were deliberately mistreating anybody. It seemed to be a general lack of knowledge.

28. I can remember a big teenager running along a corridor, leaping on the back of a member of staff and slapping him round the head. The member of staff slapped the young person round the head. It was a kind of camaraderie. There was no abuse intended or anything like that. The young person might have actually quite enjoyed it. But it was a place where young people were placed because they had behavioural

problems and some had gone onto violence. I felt that encouraging that kind of camaraderie, that 'we're all pals and having a carry on' was the wrong message. The young people were there because they were hitting the buffers of what the population sees as inappropriate behaviours. We should have been trying to teach them what was appropriate. I didn't feel that they were dealing with self-harm very well either, but I can't remember what triggered me to think that. It was just an observation and nothing more than that. I don't remember any specific reports of abuse or anything like that.

29. I spoke to my supervisor and said that I thought I would do more good if I did some staff training. That way, all the children would benefit rather than the one or two who might see me in a clinic for a few weeks. I then spoke to whoever was in charge at St. Mary's and they agreed to it. The training was more about raising awareness. It's in the depths of my memory, but I think it was about things like how to talk to someone if they have suicidal thoughts. I think people are frightened that if they mention the word, people are going to do it and it will be their fault. Sadly, someone who wants to do it might do it anyway. Someone who's thinking about it might also just grab onto the hand of help if you extend it. It's not the staff who would have to deal with it if they say yes, but they could help to direct them to a professional who could help. It was things like that and finding ways to ask the right questions. We also talked about drugs and alcohol and the problems that they can cause, so they would be more informed if they were having a chat with a young person.

Role at NHS Forth Valley

30. I started working in NHS Forth Valley in 1995. Initially, I was a consultant psychiatrist. Around 2001, I became Associate Medical Director of Mental Health in NHS Forth Valley. I remained in that post until I retired in 2018. The role grew and I did more and more sessions over time. It didn't just involve forensic psychiatry, but was for all mental health services, including being in charge of Child and Adolescent Mental Health Services (CAMHS) including being and any new service developments in mental health.

31. We had several female patients in our service who had a history of quite extreme abuse. Most of them had borderline personality disorder. Their self-harming was extreme and they hadn't been able to be managed locally. Historically, they'd ended up in units outwith of Forth Valley, some in Scotland and some in England and at huge cost to the NHS. I would go to visit them occasionally. The patients were away from their families and I wasn't entirely convinced that we were getting our money's worth. They often weren't making a huge amount of progress.

32. I made a bid to bring the money back to Forth Valley and open a unit in our own hospital. We converted one of the vacant wards we had and brought in a consultant who had worked with females at the State Hospital. We tried to develop a service so that it was nearer the patients' own families and they could hopefully eventually re-enter their own communities again. It was a residential unit. I can't remember exactly when it opened, but it was still relatively new when I left in 2018. Until then, families were having to travel the length and breadth of the country to see their relatives and we recognised the importance of addressing that.

33. I worked in different prisons as a senior registrar, but in the course of my role as a consultant I was the prison psychiatrist for the three national prisons within Forth Valley. I worked in Glenochil, Polmont and Cornton Vale for several years. As my management role increased, I gradually had to reduce my direct input. I was managing all the doctors still going into the prisons. I was head of suicide reviews for Forth Valley. If there was a suicide of a person in our care, within the prisons or known to our services, I would carry out a review and deal with the family.

Patient referrals

34. The bulk of patients that I saw were in prisons because there's such a throughput and I did it for a long time. Within the community forensic mental health service, we had several referral sources. General practitioners could refer directly into the service. Our own CAMHS or other mental health services could potentially refer someone to us.

35. We also ran a court liaison scheme for the three courts in Forth Valley every day (Monday to Friday). If someone was arrested and they were going to appear in front of the Sheriff the next afternoon, we would guarantee that one of our nurses would go and see them in the police cells if they were flagged up. They might be flagged up if they were thought to be psychotic or really mentally unwell. The nurse would carry out an assessment, which we'd trained them to do. They would then phone myself or my colleague. If they thought that they needed hospital, we would drop whatever we were doing, go and see them, handwrite a report and give it to the Sheriff before 2:00 pm. We would arrange a bed so that people weren't being inappropriately remanded into custody. We ran that free for years and years. We would get patients from that service if they didn't go into custody, were a local person and we thought that there was something not right.

36. Part of our role as forensic psychiatrists was to provide reports for the local courts, the State Hospital, lawyers and sometimes the Scottish Government. We mostly provided reports for the local courts after conviction and prior to sentencing, unless it was a murder or rape case where two psychiatrists are required to see the accused before he or she pleads. When we interviewed someone for a court report, we would sometimes take them onto our caseload if they were local and we thought they fitted the criteria for our team.

Observations in the course of my role as a psychiatrist (1989 – 2018)

Responses to inappropriate behaviours by people with learning disabilities

37. In the course of my work, I sometimes encountered a lack of response to behaviours. People with learning disabilities might not realise what was appropriate and what was not. I did go into the café of a learning disability hospital and somebody was masturbating in the corner. I mentioned it to staff and said that it wasn't appropriate. It was inappropriate for the person's dignity. Also, if they were trying to rehabilitate someone and get them into the community, they would be charged if they did that in the community. I didn't think it was fair to the patient not to address the behaviour. I can't remember the names of anybody involved, but the response was something

along the lines of, "That's just [redacted]." There was an acceptance by some of the staff that that was okay and it clearly wasn't. The patient didn't know what was right or wrong. They should have put something in place to ensure that the public were safe and that he wasn't humiliated or in trouble it would involve education.

38. I remember that incident in particular, but I did come across that sort of attitude on other occasions. There was an attitude of "that's okay and we'll just overlook it". Actually, it wasn't to the patient's advantage. It was in the back of my mind when I came to educate sex offenders with learning disabilities. I think that it was all part of the same thing.

39. I can remember people worrying that a patient had touched another patient in a learning disabilities hospital or they'd been found in a bedroom together. I don't remember cases of a patient with learning disabilities actually having sexual intercourse with another patient. It was more likely to be inappropriate touching and staff coming upon two individuals who probably didn't have the capacity to consent. Staff and parents would become upset by that so some action would be taken to keep everybody safe. I can't remember individual cases now, but I would have reported it at the time. I suppose it was people experimenting. There seemed to be a failure of understanding that people with learning disabilities do have normal sex drives and desires and they have to be helped with how to manage that.

40. I think training of staff would help when it comes to preventing inappropriate sexual behaviour by young people with learning disabilities. Training for the families of vulnerable adults would also help. People often have positive intent. A young person in their family might have learning disabilities and their family knows that they are vulnerable. They might have problems getting a social network and an education. Their parents are just trying to protect them. In doing that, it can often be a step too far for them to recognise their needs when it comes to sexual education.

41. It's one thing to educate the young person, using the right terminology and at a basic enough level for them to understand. It's another thing to educate their relatives about how they can address sexual behaviour and about the negative impact of them not

doing that. With the best intentions, they're trying to protect their relative but they're not recognising sexual drive and the exploration that young people want to do. By not telling the young person about it and not telling them how to keep themselves safe, they end up causing more problems. The education is multi-faceted. It's the same with staff, whether they're in a children's home or a foster home.

Working with deaf patients

42. I can recall an adult female patient, who was deaf. She had been abused, but I don't think it was in care. I can also recall a deaf young man, who had learning difficulties and was charged with a sexual offence. With both patients, we used a British Sign Language (BSL) interpreter for the interview. It was very difficult to get a history from the learning disabled gentleman. You have to use very basic language when you're dealing with anybody who has learning disabilities. When the person is deaf, it is particularly difficult. My sense was that the education part, which was relevant in this young man's case, was almost impossible to do on a one-off for a court report. I did suspect that some of the behaviour, rather than being predatory or evidence of deviant sexual behaviour, was inappropriate behaviour by someone who didn't realise that it was inappropriate. It maybe hadn't been highlighted that his behaviour was unacceptable.

43. I can remember trying to ask the young man about masturbatory fantasy. I clearly wasn't going to use that terminology. I pointed at his genital area and asked him what he called that. I would do that with someone who wasn't deaf but had learning disabilities. I would then go on to ask whether they played with it and what they thought about certain things. I was distracted by the signing that was happening next to me for that. The patient just giggled. I had to ask him several times and I never got an answer. I didn't know if he was embarrassed or he didn't know. It was quite frustrating and I just didn't get anywhere with it. I know that some deaf people learn Makaton, which is a much simpler version of sign language. It was a BSL interpreter that I had, which has a bigger vocabulary, but I don't know whether he understood it. This highlighted the need for specialist services for these complex cases.

44. The deaf lady was transferred down to a specialist unit in England because there wasn't an equivalent in Scotland. There was somebody who came up and did occasional outpatient clinics, but this lady needed ongoing support. She needed specialist psychiatric care and staff who could sign. We actually paid for her to go down to a residential unit in England that had signing staff in it. She got art therapy from someone who could sign as well, which was another way of expressing her emotions. It was a really good service. We hoped that would give her the best chance. I would go and visit her there, but one of the nurses went down much more regularly for meetings so we knew that she was getting the right service. It was a shame that there wasn't something equivalent in Scotland. There maybe weren't the numbers or the finances to support it, but it felt dreadful that her parents were being separated from her.

Seclusion

45. I don't recall seclusion being used for children or people with learning disabilities. The most distressing thing I witnessed was in Barlinnie Prison many years ago. It was with an adult male. I'm not sure whether he was acutely psychotic or on drugs. They took me to see him and they wouldn't open the door. They just opened the hatch. They'd put on a body belt, which I'd never seen. It was an archaic looking leather thing. His hands were restrained at the back. I'd never seen anything like it. The person was ripping the wooden strip around the window with his teeth. He was really disturbed. They had put some food into him and he had spaghetti down his face. The whole thing didn't feel right and sticks in my mind. The level of mental health nursing input in prisons has significantly improved since then.

Restraint

46. I don't think I can recall seeing any inappropriate use of restraint, but people did occasionally have to be restrained. I don't know whether there was any other way around it. I can remember as a doctor having to go and do a blood test on someone. The nurses were trained to take blood, but they couldn't take blood from this person. They were so distressed and kicking and screaming. I remember sitting with them and

trying to calm them down until they felt safe enough to allow blood to be taken. On this occasion, it was something quite important and we had to get a blood test. The nurses had to restrain the patient while I took the blood. It didn't feel right, but I don't know whether there was any alternative. We had tried different things. I don't think that it was inappropriate but others might think differently.

47. Sometimes, people were restrained in psychiatric hospitals by quite a number of staff. That could be quite distressing for patients witnessing it, never mind for those involved in the restraint. The staff were trained in control and restraint and management of violence. We tried to keep up to speed with that. It would be a three-man team because there was evidence that was the safest way to do that. As part of the restraint process, one member of staff has to be in control of the restraint. They have to stand over the person and make sure that nobody is pressing on their diaphragm and that they're able to breathe.

48. Latterly, we introduced a review process for restraints. We'd interview patients on the ward who had witnessed the restraint, and the patient themselves, and then get feedback from them. We'd review the process to see if there were any warning signs at an earlier stage and whether de-escalation techniques or medication could have been used to help. Usually, you were past the double dose of medication and they were still fighting. There was quite a strict protocol about medication. When that ran out and the patient was still fighting and hitting staff, there was no other option. In my latter years, it was often illicit drug-induced or the patient had taken spice or another legal high. They didn't seem to respond to normal sedative medication. As the consultant, I would be phoned at home and told that they had used the sedation protocol. They would tell me that they'd done it again, it hadn't worked and they didn't know what to do. It was in quite extreme circumstances that people were restrained. Sometimes, the patient would be put in a room on their own but if they were banging their head off the wall then staff would have to intervene to keep them safe.

49. Restraints usually happened when I wasn't there. I never saw it being misused, but I can't say that it was or it wasn't. We would discuss it when I came in and reviewed

what had happened. We did put procedures in place to try and ensure that there was oversight and that we could learn from it and put things in place where necessary.

Sedation

50. Occasionally, I would come across patients who were incredibly over sedated. Whether the medication was misused or had a greater effect than people had predicted, I don't know. In the early years that I worked in prisons, there was quite liberal use of non-addictive anti-psychotics, which were basically tranquillisers. They were used to take the edge off things when people were very aggressive. It was used in a manner which was off the normal licence for it.

51. Paraldehyde was an unsophisticated sedation used when someone was acutely disturbed. It was used to try and calm them down so that they didn't hurt anybody. It was used years and years ago so I have little recollection of it. It was given with something else, but I can't remember now. I think it was used very early on in my career so I can't remember the details of it.

Young people in prison

52. I trained in prisons and I then worked in prisons as a consultant in Forth Valley. I therefore worked in prisons for a long time. I would have come across young people in Longriggend during my training. When I was a consultant, I worked with young people in Polmont. I worked with young offenders in Cornton Vale both as a trainee and a consultant.

53. I worked in Longriggend once a week for a period of six months during my training. It was so long ago that I can't remember much about my work there. There would have been some people under the age of eighteen there, but not many. I was at Polmont as a consultant for several years. I think it was just once or twice a week. I worked on and off at Cornton Vale once or twice a week for eighteen years. I predominantly worked with adult prisoners, but I did come across some under-eighteens in Polmont in particular. There were a couple of young women in Cornton Vale as well.

54. It was very common for people in prison to have a background in residential care. Their experiences in care didn't appear to be particularly helpful. It didn't seem to get young people on the right track. I don't know whether they were too far down the line when they went into residential care or whether we were seeing a skewed population. My general impression was that children were being sent to places where staff didn't have enough expertise to deal with what they were being asked to deal with. I think all services improved over time and there was more psychological input, but there was a huge lacking in earlier years.

55. Young people didn't have to be unwell to be referred to the psychiatry clinic in Polmont. Even if the young person hadn't asked to be referred and they weren't unwell, the staff would refer them as a young person in quite a hostile environment who had never been in custody before. They would ask us to check that they were okay. That was proactive and positive. If there was a high profile case involving a young person, they would ask us to see them to check that they were alright. I wasn't aware of it being a protocol, but it did happen more often than not. It was unusual to have someone in prison under the age of eighteen so it was usually quite a serious offence.

56. I can recall one case in particular where the young person was referred to me. He was involved in a very high profile case, with a lot of media attention. He just sat there and said that he didn't want to talk to me. It was just to let him know that we were there. I think it's important for me to raise that there was a proactive approach at Polmont.

Culture of prisons

57. I think the cultures in prisons changed over the course of my career. When I started, Cornton Vale was all female staff. I noticed a difference, for the better, when male staff joined. It was the complete reverse in Barlinnie where it was all males and then females came. It was the same in psychiatric wards. Intensive care wards quite often had predominantly male staff. To my mind, mixed sex staffing in any environment was good. You get people who have not always had appropriate adult role models and

authority figures in their lives. Encountering appropriate male and female authority figures, that has real benefits.

58. Offenders behave differently with different genders. Even the most violent, aggressive men would apologise if they swore in front of me. They had standards and morals, they were just slightly different from our own. Offenders would tolerate lots of things, but there was still a sense of 'you shouldn't hit a woman'. Violent men behaved better when there were females around. Women could be quite catty with other women. If there were males around, they behaved better. The culture changed for the better when there was mixed sex staffing.

59. When staff is all male, it can be quite a macho environment. I can remember going into Barlinnie Prison in the late 1980s when the staffing was nearly all male. The prison officers could be quite rude. I remember having to squeeze past somebody to get past because they wouldn't move in a narrow part of the health centre. The male officer said something like, "Why do I want to have sex with every woman that I see?" They would say something inappropriate just to wind you up. I did report that to my supervisor. If you reported it, there was a sense of wondering whether they'd back me up if there was a problem. I would wonder if it might be better if I didn't report it, which is not healthy. That was a culture in the early part of my career that did change for the better.

60. I didn't really see how staff dealt with prisoners in the male prisons. More often than not, prisoners would be brought to me at the health centre so I didn't get an opportunity to see what was happening in the halls. I did occasionally visit the halls, but not a lot. Most of my experience was in Cornton Vale because I was there for so long. I worked in the remand unit and I was in and out of there all the time. They got better and better at detoxing people and trying to support them. The staff couldn't always verbalise what was wrong, but they knew their client group very well. They would ask me to see someone because they knew she wasn't right. We trusted each other. I knew that they handled a lot of difficult behaviours and a lot of self-harming behaviours all the time.

61. I used to praise the staff at Cornton Vale. They were working with some of the most emotionally damaged women. They had really difficult behaviours to manage. They dealt with them really well and sometimes a lot better than hospitals dealt with the same people. I think that was because they knew the women well. It was also because they could take things out of a cell and make it as safe as possible. If necessary, they had anti-ligature clothing and showerheads which you couldn't attach a ligature to.

62. The numbers of prisoners under the age of eighteen were small. It was very unusual for someone under the age of sixteen to be held in Polmont. I know that there was more of a focus on education for young offenders generally. There is academic education, which is important because a lot of them have literacy problems. I think that education in social skills and problem solving is really crucial, to let people know that there's another path. Addictions and self-harming were big problems. Young people needed strategies for managing them. I don't know whether there were separate services for that.

Female offenders

63. The overarching themes I've noticed with female offenders probably relate to prisoners too. I saw so many of them doing prison clinics all of the time. You would see the same patterns in the outpatients as well. Overwhelmingly, the themes were a history of physical, emotional and sexual abuse sadly, that was the norm. That was the norm. It was unusual if you had a patient who didn't have that as a child. I'd be seeing them in adulthood. That history was particularly prominent in the female prison population at Cornton Vale. It was absolutely overwhelming, the amount of abuse experienced by the women there. That obviously doesn't mean that someone who has a history of abuse will go on to offend, but there was a high percentage of people who had that kind of background.

64. The women I treated in Cornton Vale didn't have classic post-traumatic stress disorder. They wouldn't meet all the diagnostic criteria. They did have post-traumatic stress type symptoms, such as flashbacks, nightmares and things like that. The history they would give me was that they had been abused as children. They would be

struggling with these symptoms. They weren't getting the support at home to deal with that. Often, if they had tried to report the abuse, it wasn't being believed back then. I hope that might be different nowadays. What would happen was that they would get involved with people who did appear to show some interest in them, but these were often not the most reliable people in the community. They were prone to being groomed and also to getting in with the wrong crowd. If they got in with the wrong crowd, they'd be dabbling with drugs and alcohol. They would often use these to blank out the post-traumatic symptoms. They then got into offending to fund the drugs and alcohol or be involved in other offending and they'd end up in custody.

65. They would be detoxed quite well in Cornton Vale so they didn't suffer too many withdrawal symptoms. The problem was that when you come off drugs and alcohol, you don't sleep at all well. They would be prone to nightmares and flashbacks at night. They'd end up in the psychiatrist's clinic because they were self-harming during the night. That was one of their coping strategies. They often didn't have the verbal vocabulary for emotions. They would describe the self-harming not as suicidal intent, but that they could cope better with the physical pain rather than the emotional pain.

66. People with that story were a huge focus in the female prison. It was quite overwhelming if you took students in with you. They would be quite traumatised when they came out. You might go into a clinic with eight new people in the course of an afternoon, which is far too many for a psychiatrist but there was nobody else to see them. It was non-stop abuse histories. If you see that all the time, you develop your own coping mechanisms to deal with that. People sitting in with you could be quite traumatised by it. We heard the same story so often that emotionally we had to shut off from it after each case, in order to help the next person.

Self-harm/suicide in prison

67. I'm sure that I did encounter young people who had self-harmed or attempted suicide in prison, but I didn't see people according to age. It would be unfair to try and remember it by age. It's very common in custody, particularly amongst females. There was a culture of self-harming in Cornton Vale. Sadly, if people know that they're

coming into custody, it's particularly difficult with females. If they're drug users or people who self-harm and they go to court, knowing they're likely to be getting remanded or given a prison sentence, they quite often bring [redacted] with them. Females have a vagina where they can hide it. You can't get it out because you're not allowed to examine them there. You can x-ray them and know that they have [redacted], but you can't get them out.

68. The highest observation level in prison is every fifteen minutes. If you have [redacted], you can do a lot of damage in fifteen minutes. The women were particularly difficult to manage in terms of self-harm because of that. Occasionally, I would ask that the door be kept open and staff be present 24/7. That would breach prison security but they did do it in exceptional cases. We did ask for it sometimes because we couldn't keep them safe otherwise.

69. I was a trainee when there were a number of suicides at Cornton Vale. When I became a consultant, they were rebuilding the remand unit. We were involved in discussions about that and we suggested that they go to the State Hospital at Carstairs for some ideas. The staff at Carstairs could give them advice about viewing hatches and anti-ligature points for the showers and door handles. They were quite consultative about that at Cornton Vale and generally I thought they did very well.

70. In the prison setting, they could strip the room back to a mattress if they had to, if the women were using anything and everything. If you gave some women [redacted]. There was only so much staff could do when the behaviours were so extreme, but they did really well. In a hospital setting, you can't strip a room back like that so it's actually harder to keep a patient safe. Patients are in a ward where everyone else is wandering about and they have their ordinary clothes on. In a prison, there are more restrictions so they can actually manage someone more safely.

71. We were paying a lot of money for a patient to be cared for in England. She was a prolific self-harmer. I went to visit her and the patient was naked in their room. I'm not suggesting in any way that the staff were trying to harm the patient or humiliate them,

but they had run out of options. Everything they gave the patient was being ripped up and used [redacted]. It's not an easy population. Most of the women in Cornton Vale had significant abuse histories when I interviewed them. They were quite emotionally damaged by it. I have to give staff at Cornton Vale credit because in the circumstances, they coped very well with it.

72. Many years ago, I can recall attending a meeting held by the Scottish Government. I'm not sure when it was but it was definitely more than ten years ago. It was attended by the great and the good from the State Hospital and various other services. It was about deliberate self-harm and strategies for managing it. I'll never forget them going round this huge table. At the time, they were saying that you shouldn't make a big deal out of minor self-harm and if the person got attention, they were more likely to do it again. What we were advised to do was give them something to clean it up, but not make a big thing of it. It was all very academic and about what the research said.

73. I was quite incredulous. They got all the way around the table and I asked whether anybody had actually worked at Cornton Vale. We had women who were bringing [redacted] and [redacted] into the prison in their vagina. They had ready access to those items. We couldn't take them off them because they were hidden inside them. If they were helping to clean the toilets, they would get [redacted]. Someone cut off [redacted] It was quite extreme. You couldn't ignore it. You couldn't say to prison staff that they should just play it down. It was very difficult for them. I sometimes feel that we don't speak to people on the ground enough about the issues that they're facing. It felt like quite an academic exercise. I can't remember now what the outcome of that meeting was. I just felt that I had to represent the reality of the prison, and that a one-line strategy didn't cover all the nuances of the reality on the frontline.

74. In my experience, people with borderline personality disorders almost always have a history of abuse. They were often prolific self-harmers. The police would pick them up and bring them up to the hospital. Someone would say that they had personality disorder so inpatient care wouldn't help and would just reinforce the behaviour. The police would then be left with someone who was vulnerable and voicing that they were

going to kill themselves. They wouldn't feel safe to let the person go so they would charge them with breach of the peace. They would end up in a cell and appear before a Sheriff the next day. The Sheriff would be frightened that they would kill themselves if he or she let them out. Quite often, they would be remanded for reports and end up in Cornton Vale. You then had all the women from the whole of Scotland with the most extreme borderline personality disorders and a history of self-harming and abuse in the one environment with staff who were not trained. There's something wrong with that. I don't know what the answer is. It's not an easy problem.

75. I think over time there has been a bit more psychological intervention in the prisons. Local psychiatric services also started developing services to treat the borderline personality disorder client group. There was some movement in the right direction. That's not to point the finger of fault at anyone, because they are incredibly difficult patients to manage. I think you had to physically be at Cornton Vale to realise what a difficult place it was to work in and how damaged the prisoners were, emotionally and psychologically.

Discipline in prison

76. My recollection of discipline in prison is mostly that prisoners would lose privileges. The TV would be taken out of their room or they'd only get to exercise on their own for a short period of time. They were behind the door more. My impression was that if prisoners were behaving, they could gain things for example. They could get their TV, they could get to go to the gym, they could get to education, they could get to learn how to be a hairdresser. They were trying to give positive reinforcement for good behaviour and it wasn't all about taking stuff away, locking them away and being horrible. That wasn't the impression that I got. Cornton Vale is the prison that I can speak to the most and that was just what I saw. I obviously don't know what else was going on in the prison.

77. The women at Cornton Vale often came from very abusive backgrounds and were in and out and in and out of the prison all of the time. They didn't have strategies to cope in the community. It would escalate to such an extent that they would do something awful and get a lengthy sentence. When they got a long sentence it felt like they had a chance. They were then in long enough that it made it worth their while to behave because they could get privileges and a better quality of life. That learning process of realising that when you do something good, there's a positive consequence, was worth it, because they weren't getting out the next week. They weren't fighting the system. They had to work with the system to get a better quality of life. Over time, they were with the same role models, in terms of staff who set boundaries and consequences. They had appropriate adult role models. They started to trust the staff and respect them.

Treatment of prisoners

78. Long-term prisoners were also in long enough and off drugs long enough to engage in some psychological interventions. You couldn't do that if they were on remand or on short-term sentences. If you'd opened a can of worms, they were talking about really difficult things and when they got out they would go back to their own coping strategies. If they took the same amount of drugs that they had been taking before they came in, they could accidently overdose because their drug tolerance had gone down. If people got out prematurely, they quite often suffered from accidental overdose or death. You couldn't open this can of worms unless they were actually in long enough to do the work and learn new emotional coping strategies. Longer term prisoners did better. I don't think short-term sentences were particularly useful.

79. I felt that prison staff were alive to the mental health needs of prisoners and referred them to my service as needed. If you were in the community and you were referred to a psychiatrist, you could wait for quite a period of time unless it was an acute emergency. There are psychiatrists in most prisons twice a week. If there was something urgent then a prisoner would be seen quickly. The most they would ever wait was a few days. There were also mental health nurses in the prisons.

80. In Scotland, if we saw someone who was acutely psychotic and needed to be transferred to hospital, we would get on the phone and find them a bed. We would get in touch with the Sheriff and the Procurator Fiscal. The paperwork would be done and we could turn it around by the next day if it was urgent. In England, you would hear of prisoners languishing for months and months, waiting to get a bed. It will fluctuate and I don't know what the position is just now with beds. It's challenging, but we could usually sort it. The prison staff did normally know that if they contacted us, there would be some action. Occasionally we would go in on days when we weren't usually there, if there was something urgent.

81. I'm not sure how the service for young people in prison compared to the service they received in the community. If a young person in prison was acutely unwell and the prison staff were worried about them, I think that the prison psychiatrist would see them very quickly. However, to get them into an age appropriate hospital service is a different matter. When I was managing the prisons, I do remember a case when one of my colleagues had seen a young person. They were needing to be transferred out of the prison, but we had to wait until he could get a child and adolescent psychiatrist to come into the prison. That caused a delay and then we had to find a bed. As I recall it, there were a lot more hoops to go through than there would have been for an adult prisoner. Polmont is a national resource. If you were trying to get a psychiatrist from elsewhere, who had their own clinics, to travel to Polmont at a time when they could get into Polmont, it was more difficult.

Abuse

Abuse in prison

82. I don't have any recollection of people reporting abuse that took place in Scottish Prison Service establishments. They were more likely to report abuse by other prisoners. In Cornton Vale, there was a revolving door population. It was the same people going in and out all the time. The other prisoners would know who was coming in. If it was a drug user or someone known to self-harm, the other prisoners would know that. On more than one occasion, a female would come into my clinic and tell

me that they had come into prison with drugs hidden inside their vagina and they had been attacked in the showers by other prisoners. They had been held down and the drugs had been manually evacuated from inside them. It was really paramount to rape. The women were quite traumatised by that. It was reported to the prison, which had its own process for dealing with that. That was quite horrific. Often, these were women who had been abused and were re-traumatised by what had happened. From what I saw, the bullying culture in prisons was by other prisoners but it might be that was what they reported to me.

Reports of abuse/abuse of children in care

83. I didn't come across accounts of abuse within institutions caring for children. I wasn't a member of staff working in those institutions for a protracted period of time.

84. It was very common to hear accounts of abuse experienced as children from patients. Such reports are partly to do with the history taking techniques of psychiatrists or other professionals. I routinely asked people and they told me. If you're willing to hear it then people are more likely to tell you. Were they abused in care or were they in care because they had been in an abusive situation? I think most of the reports that I received were that people came from an abusive home backgrounds and had gone into care.

85. I don't think that many of my patients reported a positive experience in care, but they were less likely to report abuse per se that had taken place in care. I don't think that they were holding back. My impression, and it's only an impression, was that we were asking carers or staff in care settings to deal with the most troubled individuals with really challenging behaviour. We were asking people who hadn't had a significant amount of training to look after them. I think that was difficult. I don't know that the experience in care was necessarily a positive one but I don't know that it was abusive. I don't think that they were holding back from telling me about abuse in care. I think that they were reporting that it had not been a good experience, particularly supportive or helped them to get back on track. The most emotionally damaged or behaviourally disturbed people were all being put together. They were young so they didn't have the

coping strategies or ways to deal with peer pressure, abuse or bullying. It was a bit of a melting pot. The problem with those institutions were compounded by the fact that there were emotionally and behaviourally disturbed young people being managed by staff who didn't appear to have adequate training to deal with the issues emerging.

86. The other thing is that a lot of people we saw as patients were from more deprived backgrounds. Parents might be using drugs and alcohol and could be less careful about protecting their children. They might have parties where people were intoxicated in the house when the children were there. People wouldn't notice someone going up the stairs and disappearing for a while. You would hear those kind of stories. You would also hear that parents were neglecting the children so they weren't being fed properly or didn't have appropriate school uniform and that kind of thing. Some neighbour or family friend or boyfriend of mum would come along and give them new trainers or toys or sweeties. There were a lot of stories of children being bribed and being told not to tell or they wouldn't get things and this felt like grooming behaviour.

87. I think people found it hard to report abuse because they felt guilty. They thought that it was their fault and that they should have known. One of the most important things was to say to them that at the time it was happening, they didn't realise that they were being bribed or abused. It was only as adults that they had realised they had actually taken trainers or sweeties or money for sexual favours. They didn't realise it at the time. They were getting affection from someone when they weren't getting it from anywhere else. That was quite a common history.

88. Some people who have been abused report that they actually enjoyed it at the time. They then later feel awful when they realise that they've been abused and that they've been party to that. That was another psychological thing to deal with, the guilt and the feeling that they have accepted a bribe. We would have to go through the whole thing about who was responsible. The abuser was an adult who knew the rules and breached them.

Impact of being in care

89. I don't really have any observations to make about the impact of abuse in care on children. Most of the patients I encountered who reported childhood abuse had experienced familial abuse. Their negative experiences in care were often to do with the other young people in care. Some were more violent or more wayward and directed them down a path which was making things worse. The care experiences didn't appear to have been helpful to them, but I can't recall any particular case of someone reporting to me that they had been abused in care.

Abuse of children with learning disabilities

90. If children with learning disabilities are at higher risk of abuse, my personal view is that people who might have an interest in abusing children would target children who are vulnerable and less able to report what's happening. It wouldn't be any great surprise that they would target someone who is non-verbal or has poor communication skills. We would often hear of people who were abusers of children volunteering to take children out for the day, a favourite uncle or whatever. Someone with a learning disability might need more 'babysitting' or care. I think they were more vulnerable because they were more accessible as well as being less likely to report it.

91. People with learning disabilities often weren't educated enough about what was okay and what was normal and what was not. Even if they were intellectually able enough to understand that when they got the education, they might not have been articulate enough to be able to report it or felt safe enough to report it. I think the fact was that people didn't always know what was okay and what was not, so someone apparently showing them affection would potentially be perceived as a good thing.

Responding to reports of abuse

92. I wasn't in a team where I was responsible for children. If someone in my team received an account of abuse from an adult, we wouldn't have any hesitation in contacting the police. It's so much more talked about nowadays, but potentially it might have been different in the past. We were mainly dealing with offenders. I was the health chair for Multi Agency Public Protection Arrangements for sex offenders

(MAPPA). If we got a sense that an offender had IT equipment that they were using to access images of children or contact with an ex-partner who had children, we would report it to the police straight away.

93. My gut feeling is that things weren't so well reported in the past. I think people are just so much more aware nowadays. When I was doing my training, asking someone about a history of abuse was quite new. Abuse had been happening, but it was under the radar. If you don't ask, people don't usually tell you. It was quite uncommon to ask these questions when I was doing my training.

Residential care of my sister, [redacted]

94. My sister's name was [redacted] and her date of birth was [redacted] 1961. She had learning disability, physical disability and sensory impairment. My parents were told that she was deaf, dumb and blind. She could hear a tiny bit, but we were never able to communicate with her. She did respond to some sounds so there was something there. She couldn't sit up, she had epilepsy and she was incontinent. She went into care when she was about eighteen months old. My parents were advised that she would need long-term 24 hour care.

95. [redacted] went into Waverly Park Home in Kirkintilloch. She was cared for there in a sort of adult cot. My recollection is that [redacted] was in a kind of nightingale ward. She was in a metal cot with bars at the side. There were nursery rhyme pictures on the wall, but I'm not sure whether that had anything to do with the age of the people there. She was always under the covers in one position. Apparently, when she was younger she would break her bones if she hit her arms off the bars. She didn't have brittle bones disease so I don't know what caused that, but she was kept in a foetal position with blankets on so she didn't hit her arms and damage herself. She got contractures and ended up that shape. All her muscles were set in that position and she ended up in a Z shape. She didn't grow to full size.

96. As a young child, I would visit [redacted] at Waverley Park every week. That was it. I don't really have any recollections of it as a young child. Sometimes we would meet some of the more able patients who were able to go out to the shop. I would maybe meet them with my mum and we would chat to them. I don't recall my parents having any concerns about my sister's care at Waverley Park.

97. When [redacted] started menstruating, she was moved to Lennox Castle. She remained there until she died at the age of 23. One of the good things I would say about Waverley Park and Lennox Castle is that my sister lay in the same position for 23 years and never once had a bedsore. That's absolutely remarkable. Within a few days of going into a general hospital before she died, she had signs of a bedsore. I don't know what the staff at Waverley Park and Lennox Castle were doing to avoid bedsores, but it was noticeable that it became a problem the minute she went somewhere else.

Lennox Castle Hospital

98. I'm not sure exactly when my sister went into Lennox Castle, but it was when she started to menstruate. We would visit her once a week and my aunt visited her once a week. I also worked as a nursing assistant at Lennox Castle for three summers while I was a medical student in the early eighties. I'm guessing that I was there for about three months each time. I went back there for six months when I was a trainee forensic psychiatrist at the Douglas Inch Centre, in the early nineties.

99. Because of the level of my sister's care needs, she was in the hospital within Lennox Castle Hospital. It was a bit different from the rest of the hospital in terms of the level in care. My sister had music therapy and apparently goo-ed and ga-ed in tune occasionally. We were never able to communicate with my sister. She would giggle if you blew a raspberry in her ear and that was it. The actual physical care that she received at Lennox Castle was good. When I was a student, my sister was still alive. I wasn't allowed to work in the hospital section because my sister was there.

100. Because my sister was in the hospital section, it was different than the other wards in Lennox Castle. My sister always had her own clothes. We would take them home and wash them. She never had any skin problems or anything. She seemed happy enough. You're always hit by the smell of urine in a learning disability hospital because of incontinence. I can remember that.

101. I worked in different wards each summer that I worked at Lennox Castle, male and female wards. The male wards were separate from the female wards. The hospital was made up of separate buildings.

Experiences at Lennox Castle Hospital

First impressions/culture

102. The recollections of the wards that I worked in as a student were very different from the ward that my sister was on. My induction to working in a male learning disability ward was in the summer after I left school. I was given a nursing tunic and no induction. I went to the ward and it was a nightingale ward. There were a whole lot of naked men sitting on the end of their beds. I'd never seen a naked man before. There were no dividers or anything. In the middle of the floor, there was a pile of jumpers, trousers and socks. I had to dress the men. I picked a really old man because I thought that would be less stressful. He urinated on me when I was getting him dressed, which didn't help. I was holding up trousers and the zip wasn't working. I then had to get a long jumper. If you got two brown socks, you were doing well. They were never going to be paired. It was not good.

103. As a nursing assistant, I had to bath the men at bathtime. There would be a line of naked men, standing in a queue. There were two baths in the same room. There was no dignity. When tea was served, it was a bit giant teapot. They put milk and sugar in it. There was no choice, they were all just given sweet milky tea.

104. At one point, I worked in an adult female ward. They had what they called a 'tea and pee' round. The patients were given a cup of tea from the big teapot. The staff then took them all to sit on a row of commodes to pee after their tea. There was no dignity and it wasn't good.

105. There was a lady who had been deaf but then had also lost her sight. She had learned the sign language alphabet before she lost her sight. She could teach you to make the other half of the letters. She would hold your hand and show you that if you touched her thumb, that was an 'A'. You could communicate with her very slowly if you did that. One day, she went for lunch. She would always put her hand in the food to see what it was. It was mince. She cleared her plate and they took her plate away. She went nuts and she was banging the table and screaming. The charge nurse told me to get her out of there and that she'd be getting no dessert.

106. I took the lady away, sat down with her and asked her what was wrong. She signed back to me that she wanted more mince. I went back to the charge nurse and told her that the reason the patient had been upset was that they took her plate away, she wanted more mince and nobody had asked her. The charge nurse said that she'd be getting no dessert. It was those kinds of attitude and behaviours that made me feel that the culture was not great.

107. At one point, I was on duty in a ward with around thirty men. It was just me and one nurse on duty. The nurse was drunk in the office. I was trying to feed all the patients. There were several in adult prams who needed fed. They sometimes had seizures when you were feeding them. I was having to do it all myself. That happened on more than one occasion.

108. Lennox Castle was a total institution, which is not healthy. There was a lack of dignity and personalised care. The staff were employed from the local community. They were all related to each other. If you said something, you had to watch because other people would be there. It was difficult. That's not to say that there weren't caring and good staff, but my overarching view is that it could have been a lot better.

109. I think there were some positives about Lennox Castle. The patients were afforded long-term care in a protected environment. For the most part, they were safe and there was space to move about without being subjected to abuse but there was nothing specific being done there that I thought was revolutionary. It was pretty much a total institution so they were still in an institution.

Staffing

110. I think all of the wards had a ward sister or a charge nurse, one or two nurses and nursing assistants. There just weren't enough staff for the number of patients and the number of things that needed to be done. Sometimes, it would just be me and the charge nurse on duty and he would be in the office. I don't know what supervision the nursing hierarchy would have got. I suspect that it was quite limited. I really felt that they were just in to do a job and go home. There were caring staff there and I wouldn't say otherwise, but it didn't feel like supervision was a priority.

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

112. I think there were some hospital houses nearby, just out with the gates of the hospital. Some of the staff stayed in those houses, but I don't think any of the staff stayed in the hospital itself. There would be very small numbers of nurses on shift in each ward overnight.

Role of nursing assistant

113. As a nursing assistant, my role was to make beds, bath patients, help them at mealtimes and take them out for social activities. Medication was the responsibility of the nursing staff. There wasn't really a sense of me reporting to anybody. Sometimes, it was just myself and the charge nurse on duty so I suppose I reported to him or her.

I don't remember there being a handover or anything like that. I wasn't given any training for the role. I don't remember having any supervision or education at all.

Role of psychiatrist

114. When I returned to Lennox Castle as a senior registrar, I was doing my forensic psychiatry training at the time. I had an interest in learning disability forensic psychiatry. There wasn't a service in Glasgow at the time. They were trying to get funding to create a job. Because I was forensic and general adult trained, in order to apply for a consultant post if it came up, I needed to do more learning disability. I therefore arranged to do some learning disability psychiatry at Lennox Castle. I would go there once a week and take part in the multi-disciplinary ward round. Multi-disciplinary, multi-agency care was particularly relevant for patients with learning disabilities.

115. I would occasionally see patients if staff brought them to my attention and told me that a particular patient had a problem with this or that. I think they went through the caseload at the meeting every week so they could identify any issues. That would trigger an action, if necessary. I was only there once a week so I didn't have the time to see everybody. I was trying to learn about all the inter-disciplinary working and things that would help.

116. I do remember feeling slightly frustrated because I didn't always think they were as proactive as they might have been. I don't have specific examples. I just remember that I was always saying, "But what about…?" and, "Have you thought about…?"

Patients at Lennox Castle

117. I wasn't party to the admission of patients to Lennox Castle when I worked there. I know that there were some people there who didn't have a learning disability. There were some historical cases where people had maybe had an illegitimate child many years before. They had ended up at Lennox Castle and never left. I do remember hearing about a case like that. I think that the guidance was different then. My sister

was an example of that. Nowadays, if my sister was born with the problems that she had, she would be at home. She wasn't behaviourally troublesome in any way, but she needed 24 hour care. I'm sure that the family would have had a lot to do, but there would have been services coming in. The guidance back then was different. I think a lot of people went into Lennox Castle because they had a learning disability and not because something specific had happened. I think that was the advice that families were given.

118. I can remember old terminology being used at Lennox Castle, words like 'imbecile'. That word sticks in my mind. You would see that in people's notes. That was the terminology of the time and it's changed over time. The terms "high-grade" and "low-grade" are familiar to me, along with "profound, severe and imbecile". All of these terms were still used.

119. If someone was admitted to Lennox Castle, the length of time they remained depended on the thinking of the time. It was the same with general adult psychiatry patients. There were a lot of people in long-term psychiatric care whose families were told what was wrong, that they were safe and that they would be admitted. It was the same in learning disability hospitals. Families were told that people would be taken in, looked after and they'd be fine. It was a total institution and they had a small farm in the grounds or a market garden, places where people could get a job etc. There was the bowling green and social activities and it was almost like an enclosed community. When thinking changed, some families who had been promised long term care were suddenly told that their relative was getting out at the age of 65. It was horrifying for families because they had thought that their relatives were safe in care. It was just because the thinking had changed.

Facilities/leisure time

120. There was obviously music therapy because my sister got that. I can't remember much about other facilities. I think there probably were workshops and things like that. I'm not sure because I didn't ever go to them and I don't recall people going to them. I

think there was a bowling green and that kind of thing. I think that the more able residents would use it.

121. There was a hospital disco because I remember taking patients to that. Before I left, I wanted to take the patients to the disco and see them enjoying themselves. It wasn't as if someone said that would be a nice way for me to finish off. Instead, I was told that I could take them if I bathed all the men. The other staff sat in the office and did nothing while I had to bath all the men in order for me to get the treat of taking them to the disco.

122. One of the patients was in a wheelchair and wanted to dance at the disco. He was an adult but he was the size of a small child. I lifted him up and he had his legs around my waist. We were spinning around to the music and he was all excited. I took the patients down to give them their tea and cake and the patient was covered in tea and cake. I lifted him up to dance again. He was incontinent during the song. I had a ring of urine around my waist and I was covered in tea and cake. When I got back to the ward, the staff laughed. They thought that they'd got the better of me because I was covered in urine and cake, but I was delighted because I'd seen the patients having a nice time. The culture was that I had to do all the bathing to take them to the disco. In a way, that story highlights what the culture was like and it wasn't good.

Children

123. I don't recall there being children's wards at Lennox Castle so I have no impression as to what the numbers of children may have been. I'm not even aware if there was a children's ward when I worked there.

Treatment

124. With my sister's difficulties, I don't know that anything could have been done to help her communicate. She couldn't see and she could only hear vague sounds. There was no way of connecting with her, I don't think. I think it was just a feature of my sister. I don't think that was a failure of the hospital. Nowadays, you would like to think that

there are more talking mats and aids for people to communicate when they don't have words.

125. I don't remember people being given assistance to communicate through talking mats or pictures. I don't personally remember there being speech therapy, but I wasn't involved in care meetings. As a nursing assistant, I was on the floor looking after people who were incontinent when the meetings went on.

126. I do remember pockets of really good care. There was a gentleman who probably had the worst psoriasis that I've ever seen. He had the most rigorous bathing routine, lotions and potions and dressings. We did that religiously, every day.

127. I don't recall anything about dental care or it being mentioned, either positively or negatively. I think there was a GP who came in, but I wasn't responsible for that when I was a nursing assistant. I wasn't party to any of the medical decisions because of the role that I was in. At one point, when I was a medical student and at Lennox Castle for the summer, I remember thinking that it wasn't like anywhere else in the NHS. I thought that certain things were clearly not right, such as the lack of dignity and the bathing. I remember trying to teach the staff how to take blood pressures and explaining what it was actually about. I also thought that the amount of staffing relative to the care needs of the population that they were looking after was too low.

128. I think medication was administered by a qualified nurse. I can't remember anything about how that was done. Laxatives and enemas were used, but I don't really know whether they were used appropriately or not. I wasn't aware of what medication people were getting. I don't recall lots of people appearing to be overly sedated or anything like that. I'm aware that subsequent inquiries into Lennox Castle stated that patients were overmedicated and that nutrition was poor. That wasn't my experience when I worked there or my experience of my sister's care, but things can happen elsewhere and you don't see them.

129. Just before my sister died, we got a phone call to say that she had a bowel obstruction. When they had catheterised her, she had been bleeding. They said that it was

probably due to her Von Willebrand disease, which is a hereditary bleeding disorder. Nobody had told us that she had that. We thought that was strange. She was moved to Stobhill Hospital in Glasgow.

130. As a medical student, I knew that Von Willebrand disease was hereditary and that our family should have known about it. I went to get tested, but it turned out that I didn't have it. My sister died that week. They got her records out and there was a mention of Von Willebrand disease, but she'd never actually been formally tested for it. They concluded that I didn't have it and that was good news. It did show sub optimal medical care as it hadn't been clarified and the family hadn't been tested.

131. My sister was doubly incontinent, but the staff at Lennox Castle missed bowel and urinary retention just before she died. They also said that she had this hereditary disorder, but she didn't. If they did think that she had it, they hadn't told anyone in the family. There was a lot there that wasn't great in her latter medical care.

132. Overall, I think my family is content with the care that my sister received at Lennox Castle. Had we chosen to do so, there might have been grounds for complaint when she did die. A bowl and urinary obstruction shouldn't be missed in a doubly incontinent patient. It also wasn't good practice to fail to inform her family about a potential hereditary bleeding disorder. But actually, at the end of the day, my sister was cared for very well for years. I think we were happy with her care.

Daily routine

133. I can't really remember daily routines. I can remember the 'tea and pee' round and more than one man bathing in the same room. I can remember the dressing process of all the naked men with no privacy. There was a lack of appropriate and individual clothing. I remember certain things like that. If someone wet the bed, I think we had to put paper incontinence pads down on the bed and change the patient if they were wet. I have no idea how often it was checked during the night because I wasn't there.

134. I can't remember there being different clothing for special occasions, but I wasn't there for special occasions. I worked there in the summer. I just remember the crimplene jumpers. They were patterned, brown and blue. They were awful things.

135. During the day, I think that most of the patients were in a communal living area on the ward. I think the bedroom might have been locked during the day. I don't recall there being a lot of activities during the day. I don't remember lots of interaction or ball games or quizzes. I think most people weren't able to do that kind of thing. The more able people could go out and about. In the wards I worked in, there weren't any trips out.

Mealtimes/food

136. Meals were served in the wards. There was a dining area and there would be staff in the kitchen, handing the food through a hatch. My recollection is that there were tables in the dining area. There would be prams at the side for people who couldn't sit at the tables. We had to feed them separately. I don't know that there was a huge amount of choice. If someone didn't like the food, I can't remember whether there was an alternative. I didn't think the teapot, with sugar and milk already added, was right.

137. I can remember mealtimes being quite stressful. We would be trying to feed the patients in prams in case they had seizures whilst also watching everybody else. There just weren't enough staff. I don't remember residents assisting other residents at mealtimes.

Washing/bathing

138. I don't recall if there was a wash area where residents washed themselves or brushed their teeth. I just recall that there was a bathroom that had two baths in it. That was for the bathing. I can remember men queuing up and we would physically do the bathing. I don't know how often that was. I don't think we were bathing a whole ward every day, although bathing the man with the skin problem was a regular thing. I don't remember there being any curtain or privacy in the bathing area. I remember it being very

undignified. It's too long ago for me to remember the details, but it stuck in my mind as not being right.

Sleeping arrangements

139. I think there were at least thirty people on the ward. I don't know whether they had a place for their own belongings. I can't remember that. I just remember the pile of clothes that was communal. I think we had to make sure that the patients had their medication before we went off duty, but I wasn't there when they went to bed. I don't even know what time they went to bed.

140. I don't remember there being curtains around beds in the wards, but I wasn't there during the night. When we were there, we were making beds in the morning. If there were curtains, they wouldn't have been there at that point. I just remember a big open ward and making beds. The men would all be sitting on the beds. There wasn't a lot of privacy or dignity. That's my overwhelming recollection.

Religion

141. There were chaplains at Lennox Castle. I think there was a priest and a minister. I have a vague recollection of them coming round to the wards. I'm not entirely sure whether they did a church service as well.

Work/chores

142. I have a recollection that in all of the learning disability hospitals at that time, the more able patients were given jobs to do. It would be to deliver the post or newspapers from one ward to the other. I certainly remember seeing that at Merchiston Hospital and I think that it would have happened at Lennox Castle as well. It was seen as a sort of rehabilitative thing, to give residents a bit of a role and some independence. I don't think they were doing menial things like cleaning. I think it was to practice their communication skills.

Visitors/family contact

143. My overwhelming recollection is that most patients didn't have visitors very often at all, family or otherwise. I think that was a feature of the fact that most of them had been in the hospital for a very long time. Looking back, we only went to see my sister once a week and my aunt visited midweek. She didn't know that we were there and that actually felt okay. When you look back, it sounds terrible. I think it would have been quite easy for people to just not come. Back then, you were putting them in somewhere. The expectations are different now.

144. One of the patients had a brother who was a high-profile TV personality. He came up regularly, helped at the fete and visited his brother. There were people who had visitors, but not that many. It was a rare event if someone came up to visit. It was really a forgotten population. I don't remember patients ever going home for visits.

External monitoring

145. I don't recall anybody checking in with patients to see what their care was like, although I was only there for a matter of weeks every summer. I wasn't aware of any external monitoring. I wasn't involved in anything like that as a nursing assistant or as a registrar.

Discharge into the community

146. As attitudes changed, they were trying to rehabilitate people and discharge them from Lennox Castle. The downside was that they would teach people skills, such as counting their money, running a bath or making a pot of tea, but they sometimes ended up in places where they didn't have enough support. They didn't know when to go to the shop for the milk and ended up needing it on the day the shop was shut. You can teach someone how to have a bath, but unless someone's there to prompt you to have a bath you might find them a bit dishevelled and unclean. Your learning disability doesn't go away because you're rehabilitated. You do need to have the support and I don't think that was always there. Sometimes people would fail. There was a big move

towards 'normalisation', but in my view that was sometimes taken too literally. People would say that they should just be given the same as everyone else when actually their needs were different. They had a right to all these things, but they needed support to make it right. I think that sometimes people overshot the mark when that first came in.

Discipline

147. I don't recall anything about discipline or sanctions. I don't recall someone needing to be restrained. You maybe had to grab someone by the wrist as they were coming for you, but it was literally in self-defence. I don't recall anybody being held down or that kind of thing. I can't remember people being told that they weren't getting their dinner because they'd misbehaved or anything like that. They might have been told that they couldn't go to the disco or something if they'd been misbehaving. I don't really recall anything negative as such. I'm not aware of anybody running away from Lennox Castle.

Record-keeping

148. I didn't get any training in record-keeping. I didn't get any training at all. Out of curiosity, I did look at the patient notes. I think they were quite scant. There were medical records and nursing notes but I don't know if they were shared files. I don't think there were many entries. Quite often, they were about whether the patient's bowels were working rather than things like quality of life, rehabilitation or sensory stimulation. There wasn't a lot of multi-disciplinary care planning back then. It didn't really feature.

Reporting of complaints/concerns

149. Lennox Castle wasn't a culture where you could report things. As a summer student, I would have been on a bit of sticky wicket doing that. Additionally, it was such a closed institution where everybody knew each other. It wasn't a safe place to report, which I think is an issue in any total institution.

Abuse at Lennox Castle

150. There is only one incident which I recall when I was concerned that abuse might have taken place. I was probably about eighteen at the time. A trainee nurse and another nurse or nursing assistant suggested taking the patients for a walk because it was a nice sunny day. They were both male nurses. The charge nurse said that was fine. I can't remember exactly how many patients we had. There were several patients. One was in a wheelchair, maybe two linking arms and one walking independently. I was new and I just went with them. I thought it was good, the patients getting a wee day off the ward. I was pushing the wheelchair and following the two guys up a hill.

151. We ended up at a reservoir, which I didn't know was there. I didn't think that it was a safe place to take vulnerable adults. We had taken a picnic of biscuits and juice or something. We sat down at the side of the reservoir and all the patients were round about me. The two male nurses stripped off and jumped in the reservoir. They didn't strip naked. I think they were still in their underwear. They went for a swim and left me with all these patients. I was a summer student. I was just trying to make sure all the patients were okay and didn't come to any harm. I was really annoyed and felt unsafe.

152. The trainee nurse came back and said that he would take one of the patients for a walk. I can't remember the patient's name, but he was an adult. I was really angry because the two nurses had just gone off for a swim. He took the patient behind a bush. I didn't feel comfortable about it, but I couldn't leave where I was. I couldn't see if anything happened, but it didn't feel right. I then heard a splash and I saw the patient in the water with his hands up. I screamed. The other nurse swam back and got the patient out of the water and brought him round.

153. I didn't know what to do. I was just a student and I was thinking, "What on earth?" They had laid him on his side to make sure he wasn't choking on the water. They took the dry clothes off the person in the wheelchair and put them onto the person who was soaking. They wrapped the person in the wheelchair in a blanket. Everyone was okay, but it was terrifying and horrible.

154. Other than the incident at the reservoir, I didn't witness any other incidents of abuse at Lennox Castle. That one sticks in my mind. There was a sense of a lack of expectations for people. I think that did gradually change for the better with 'normalisation' and de-institutionalisation. When I worked there, I think there was a lot of institutionalisations of both patients and staff. There were a lot of behaviours that were accepted and unchallenged. The teapot pre-filled with milk and sugar summed it up in a teapot. There was no choice and no dignity, that was it.

Reporting of Abuse

155. To this day, I still question myself and whether I reported what happened at the reservoir in some shape or form when I went back. It was clearly unsafe and not right. I wasn't sure what had happened behind the bush, but it was such a total institution that it was really difficult. I think I tried to tell someone but nothing happened. That's the bottom-line.

156. Reporting of incidents and learning from them became a big thing for me as a consultant and as an associate medical director. It stems back to that sort of thing. It wasn't right. That was the overwhelming incident I remember at Lennox Castle when something went wrong. It wasn't right and there was something about the culture where I didn't feel safe.

157. I'm someone who is quite happy to speak out, but it just didn't feel safe in that environment. It was to do with the total institutional thing. I felt I couldn't say something because everyone seemed to be related to someone else in the organisation. You've got to work with these people and you need them to have your back. It's difficult. The culture was wrong for reporting. There was no threat telling you not to report concerns, but it was the local employer and everybody knew everybody else. I was aware of phone calls to wards, letting them know that someone was coming. I knew there was that kind of back covering culture. I was also aware of behaviours such as members of staff being drunk whilst on duty and that not being dealt with.

158. Later on in my career, I always tried to encourage staff to learn from incidents and emphasise that it wasn't a blame culture. It was about learning what we could do better for the future. That was really important to me in the course of suicide reviews. It shouldn't be about trying to point the finger. It should be about what we can learn.

Lessons to be learned

159. I think that Lennox Castle was too big. There are economies of scale and potentially you can have lots of services in a bigger place than you can in small units. You can't possibly access specialist services so readily if everybody is split up. There's a middle ground. I think Lennox Castle went too far and it was too big. It's hard to monitor what's going on in an institution. I don't think there was enough external oversight of what was going on. You're not going to get incident reporting in the total institution situation.

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

161. Teachers in schools need to be very vigilant about behavioural changes. The child might not be able to tell you, but if there's a change in behaviour there's usually something that has triggered it. They need to be taught how to elicit what is going on. I think education is the most important thing.

162. 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. November 24 .....