Scottish Child Abuse Inquiry

Witness Statement of

Samantha SMITH

Support person present: No

1. My name is Samantha Smith. My date of birth is [redacted] 1967. My contact details are known to the Inquiry.

Background

2. I have had a somewhat unusual career trajectory. I am not a social worker by training, my introduction and involvement with social work practice came as a researcher.

3. My qualifications are more academic than professional. My initial degree was a joint Honours that specialised in disability, which has been a particular interest of mine that started in my teenage years. I have a Masters in Applied Social Research and a PhD, the title of which is 'Living with Risk'. It looks at how adults with learning difficulties perceive risk, trying to view the subject from a different perspective. I also have a LLM in Human Rights Law.

4. I studied for my Honours down south and after graduating worked with adults with learning disabilities at various day centres in the East End of Glasgow while I was gaining my Masters. Initially I was on the temporary register, working when I could, before I then became a day centre officer.

5. Around 1996, after I had been away travelling around the world for a year, I took up a position as a Commissioner at Lennox Castle Hospital, after it had been decided to partially close the hospital. Previously, following market principles, health boards had created a purchaser and provider split, where the Community Mental Health Services Trust was the provider overseeing the operational aspects of health services, which in this case was the running of Lennox Castle Hospital. The Health Board then decided,

with political agreement/direction, that it no longer wanted to 'purchase' institutional care in that way. It agreed to a closure programme that resulted in resource transfer to Local Authorities for the ongoing cost of supporting former residents.

6. As part of the Joint Learning Disability Team, we Commissioners were tasked with ensuring Greater Glasgow Health Board funded individuals in other long stay hospitals were also supported to move. That included residents in the Royal Scottish Hospital at Larbert, Merchiston, Kirklands, Birkwood, etc. As that evolved, however, that idea applied to everybody except a certain group who were seen as particularly challenging.

7. I had done some research work with a colleague who was a senior social worker, before they themselves had gone to work as a Commissioner. Someone had gone on maternity leave and she got in touch with me and suggested I apply, knowing my interests. When Margaret, whose maternity leave I had been covering, came back, the hospital closure programme was at a different stage and so a position was created and I carried on working there.

8. On 1 May 2001, I founded C-Change, which is a charitable organisation with a focus on helping people who need additional support in their lives.

Lennox Castle Hospital, Lennoxtown

Layout

9. Lennox Castle Hospital sat on an extensive site outside Lennoxtown in East Dunbartonshire. The castle itself was at the top of the site and a number of buildings containing the wards and various services were located down the hill from it. There was also housing on the site that some of the doctors and others had lived in previously, although I don't think the houses were occupied by the time I was there.

10. There was a canteen and a laundry and there was a building halfway up the hill that had been a morgue, but I think it was shut by that time. There was also a bowling green and a gallery with a shop on the bottom floor for the residents. It always looked

like a thrift shop to me. At the top of the gallery building were offices where the Assessment and Commissioning Teams worked.

Background to decommissioning

11. At one point, Lennox Castle was the largest facility of its kind in the country, but it went through a series of contractions before it was ultimately agreed to close it down. There had been quite a few scandals, primarily south of the border, and a white paper was produced that basically made clear that nobody should be living in a hospital as a lifelong place of residence. It is my understanding that the decision to close Lennox Castle was made on the back of that.

12. Quite a few of the residents of Lennox Castle were not formally detained, they were informal patients, although those people might not necessarily have known that. My understanding is that, generally, as society's awareness of that fact shifted, people who weren't detained were moved.

13. The closure of Lennox Castle Hospital was not universally accepted as the right thing to do at the time I started. At first, it had only really been agreed to close the top site. Hospitals, however, are meant to treat people for something that is treatable, not for ongoing distress and so later on we got agreement to close the whole of the hospital. In 2002 it finally did close.

14. A big part of the process of closing Lennox Castle was finding the right accommodation for people. There had been a hospital closure programme south of the border that had been done by creating mini-institutions and oftentimes people were moved into units of six or twelve. It was decided that was not how Lennox Castle should close, but instead we should support people into non-registered accommodation as much as possible. Non-registered accommodation is the difference between ordinary or residential living. Tenancy rights or being a resident with an occupancy agreement. It was largely based on size and the definition of houses of multi occupancy. As we were trying to avoid creating mini institutions, we endeavoured to ensure people moving out of hospital had tenancy rights and didn't move into registered accommodation.

Staff structure

15. As far as I understood, the trust manager who oversaw Lennox Castle was Susan Brown. Michael McCue worked under her and there were also a number of staff employed for day-to-day practicalities.

16. When I started, there was an Assessment team and a Commissioning Team. It was the job of the Assessment Team to go onto the wards, conduct assessments of the residents and write up essential lifestyle plans for each individual living there. These essential lifestyle plans were documents that should then give us Commissioners the key information required in order to work out what the best services would be for each person.

17. The commissioning role was to link with housing associations and provider organisations, who in turn would work with and support individuals to help them move out of the hospital. Thereafter, in a planned way, the various wards of the hospital would close. We concentrated on the top site wards first, before continuing with the bottom site wards. I commissioned the closure of some of the challenging behaviour wards and helped people to move out of them.

18. I can't remember the names of those on the Assessment Team, but John Dalrymple headed up the Commissioning Team and was the project manager. He liaised with Susan Brown at trust level and Julie Murray, who was the health board link. It was not an easy relationship. Gina Hagen was his deputy and my line manager. Michael, Pauline, Nicky, Margaret and I were the rest of the Commissioners.

19. There were a few psychiatrists, including Dr Oman, Dr Sinclair and Dr Linda Casanell. My recollection is that Dr Sinclair retired and then came back and did some work, although I am not certain of that. The psychiatrists would primarily be our link to individuals if there was any issue or contention. Different psychiatrists would take that lead at different times.

20. There were also psychologists. One was Keith Bowden and another was Lyndsay McNair. I think Keith was senior and he worked with Michael McCue and with residents with more challenging behaviour.

Children

21. There had been children's wards previously, but not by the time I worked there. I was not particularly aware of there being any people under eighteen when I worked there either. Sometimes people would come into two of the wards from outside who might have been under eighteen, but we wouldn't commission for them because they weren't in permanent residence.

22. Many of the people we commissioned services for had been resident in the hospital since childhood and there were definite points at which children came into the system. I helped commission services for people who had been in Lennox Castle since birth. Another pinch point was when a child was to be starting primary school. Oftentimes they might not be able to get a school placement and parents would be advised that they should be admitted. Another pinch point was adolescence when, whatever might have been happening, if hormones are added and families do not get the support that they need, they are unable to cope.

Role at Lennox Castle Hospital

23. Everyone knew what we Commissioners were there to do. The psychiatrists and psychologists were the primary medical staff we engaged with, but on a day-to-day level, if we needed information, we would speak with the staff on the ward, whoever was there. If there was an issue with provider staff getting access, or perhaps with how things were progressing, we would liaise with the ward manager to encourage forward movement.

First impressions

24. I had been to Lennox Castle Hospital before I started in my role as a Commissioner. I had done a music therapy course at the hospital while I was doing the day centre work. I was shocked then and it remained a fairly shocking place to work.

25. I was shocked by the everyday nature of things that I just wouldn't want. Wards were mixed gender and were categorised by levels of function and therefore there were groups of people with profound and complex disabilities together. Some wards were locked and on some there were people, who were clearly heavily sedated, lying with no clothes on. People were wandering aimlessly around and their personal space was a bed with a curtain around it and a bedside cabinet where they could keep their personal belongings if they wished. Lives were without meaning and purpose.

Daily routine

26. The general routine for the residents primarily focussed on them being fed, put to bed and medicated. There were other aspects of support, but there was no real focus on human flourishing, it was more about maintenance. That wasn't necessarily the intention of everybody who worked in the hospital, but there was a general degradation.

27. There was an expectation that everybody fitted in with whatever happened on a ward. Residents were expected to be in bed at certain times and to be awake at certain times. There was a routine with regard to washing and bathing and staff would be present to supervise. People would sometimes be waiting to go and bathe in a state of undress.

28. There was very little to keep the residents occupied. They could come into the bottom of the gallery and they could go into the shop, but generally they spent their time living on the wards. There were communal areas on the wards, but the televisions were often high up. The TV might be on, but there would be no choice as to what was being viewed, or if you wanted peace and quiet. Latterly there was a person-centred planning team in the hospital, which I'm sure was well-intentioned, but if you don't have a choice as to who you share a room with, how person-centred is that?

29. I never observed the nighttime routine, although I do know there would have been night staff on duty. I would imagine it would have been fairly low-level supervision at night.

Bedwetting

30. There was a punitive, sometimes arbitrary, 'management' of resident's 'behaviour'. In response, residents would find ways to exert some control in a system where they had very little. Incidences of noncompliance with their medication, rule-breaking, and of urinating and defecating in places one shouldn't were not unusual.

31. On occasions, ward staff would ascribe intention to behaviour that was unintentional in nature and the response to bedwetting or incontinence would have been determined by how staff viewed it had occurred. If someone had been using bedwetting as a protest, the response would have been different to if someone had had an accident. I didn't see it happen, but if it was considered to have been a protest and if the person was able, they would have had to clear it up themselves.

Mealtimes

32. My understanding is that all meals were served on the ward. There was a canteen and those who were able could go there, but folk didn't generally have much money. If a resident didn't like whatever they had been given, there was no alternative, they would just go hungry. There was no choice of when they would eat, or what they would eat. There was really a lack of power and choice over their day-to-day lives generally and, if you are able and you expressed your distress and upset about that, your behaviour would be managed.

33. One of the things that was really noticeable was when student nurses came to work. They would see things and be horrified and they would be the ones who would raise complaints. A student nurse came onto one of the wards and saw one of her colleagues mixing a person's meal because they were on soft food. The nurse complained because they were mixing the main course and pudding together, but their

colleague's response was that it didn't matter because it all went down the same way anyway.

34. Another thing would be residents not having a choice of how they had tea, if they had it. Tea was always made up in a big pot with milk and the equivalent of two sugars added and then delivered to everyone en masse.

35. You could take the view that you could live with any of those things if they happened once or every so often, but when all that is happening all of the time and it is everywhere, it is different.

Clothing

36. Notionally, residents would have their own clothes, but they were all washed together and people might not get the same things back. It was pretty much the same for everything, including underwear. Families would complain that they were bringing things for their relatives and never seeing them again and when people were leaving the hospital, they were doing so with a black bag full of things that might not necessarily be their own.

Finances

37. Residents should have had a hospital allowance, but other than the shop and the canteen, there was nothing really to spend it on. Instead, staff would take decisions on how their money was spent. They would, for example, get a present at Christmas, but that present had been bought with their own money.

38. I recall that there were some tussles over the transferring of resident's finances when they moved. Everyone would get state allowances, but some people had more significant amounts money, which would have been held in trusts. It might have been money that they'd inherited or money from criminal injuries compensation. It would depend on the status of the individual whether they would have someone appointed to deal with their finances, but it wasn't a straightforward task in every circumstance.

Relations between residents

39. Relationships between residents was a forbidden activity. If people wanted to have a relationship, they weren't allowed to conduct it on a ward and if they were having sexual relations, they would have to do so outside in the grounds.

40. Some of the residents were not able to self-ambulate and so would be reliant on someone else. Therefore, even if they were on an open ward, they were stuck inside and not able to go out unless assistance was available. Sometimes other residents would support those who weren't able to self-ambulate and you would see people out and about. Some relationships had been built up over time and some of them were caring.

Healthcare

41. The odd thing about Lennox Castle being a hospital was that people's health was not maintained. It was a hospital in name only and that was often an issue when people moved out and registered with a local G.P.. There was a G.P. who provided health support, but a number of people left Lennox Castle Hospital with undiagnosed health conditions, including heart conditions. There were also similarities in the medication that people were on. Many were on anti-constipation medication or stomach medication.

42. A drugs trolley used to go round the wards and people would either be given their medication to take, if they were able, or it would be administered to them. Some people were quite creative and would take their medication, but not actually ingest it.

43. There were other issues about the hospital in terms of some of the medications that were being used. I remember 'Paraldehyde' being given as a reason why someone shouldn't move because it was particularly tricky stuff to deal with. As a Commissioner, I had to consider how it would be possible for that person to get this medication and I looked at how it would be administered in the community. It was only then that I realised that very few people in the community were actually prescribed it, but instead were prescribed an alternative.

44. One of the things we strongly encouraged providers to do when they were supporting people, and something that we at C-Change did ourselves, was to register people with the local G.P. as soon as they left hospital. They then would get a comprehensive health check, after which there would often be a planned process of review of their medication to ensure they were only on the medication they needed to be on. Anecdotally, once people's medication was reviewed in an holistic way after they had left hospital, it would often be changed.

45. I was not aware what dental care residents might have received. We did, as Commissioners, have the opportunity to look through people's case notes and they would record certain things, such as if a person didn't have their teeth because they were known to be a biter. I didn't see this happen, but I did see it recorded in the notes of a resident that we were working with that they had had their teeth removed because they had been biting.

Trips and holidays

46. There were organised trips occasionally, including to a caravan park somewhere, although I'm not sure where. The hospital had a minibus and some people would get out on the bus, but there wasn't enough room for everybody and consequently not everyone was allowed to go. Oftentimes, people who didn't get on the bus would just be left lying in the ward.

Work

47. This didn't happen while I was in the hospital, but people would talk about having to work for local farmers historically. There also used to be a group called the 'Blue Maids' who would do chores around the hospital. My understanding is the Blue Maids were residents who undertook domestic chores, cleaning and the likes.

48. There was a more informal process of people being used as runners, going to get things for others in exchange for money or other things. Some residents were also used informally as part of the workforce to assist with other residents.

49. Some people liked helping out, however oftentimes they would help out people who were less able to say whether they wanted to be helped by somebody they lived with. It would be hard to determine from the point of view of the person who was being helped whether they would have preferred it to have been a member of staff or not. I never heard of any resident helping another with their personal care, however.

Culture

50. The wards where people had greater degrees of complexities and profound disabilities operated quite differently to other wards where the residents were more out and about. Additionally, different wards had different cultures and that was down to the leadership of the ward manager, some of whom were longstanding and might be quite protective of their residents. Some wards were more static because the ward manager would resist having flows of different people coming in and out. Other wards were less so.

51. Families would raise things around both the care and the treatment of their loved ones. Residents would too. Sometimes a resolution would be sought. Sometimes a decision would be made that certain things needed to be done differently, but then it would slowly go back to how it had been. It wasn't that everything was bad, it was just that low-level, institutional degradation.

52. I recall a younger woman called [redacted] who liked bright clothes. She was on a challenging behaviour, mixed ward and she was extremely distressed and would quite often be naked. That was accepted as the norm and not considered unusual behaviour on that ward. You would walk into that ward and there would be someone sitting on a chair in the hall, others were lying on the floor and others were walking around naked.

Contact with residents

53. I used to go into the wards I was involved with, the ones which were closing down, and speak with the residents. Additionally, people could come into the gallery where I worked and get a cup of coffee or tea if they wanted and have a chat. Some people knew who I was and that I had some kind of role in their upcoming move. Some were really excited at the prospect of moving.

Visitors

54. I would not say relatives were encouraged to visit, although they were able to do so. If relatives did wish to visit, they were encouraged to do so at certain times, for example not at bath times or meal times.

55. Some families were more welcome than others and one of the things that would be said to discourage certain visitors would be that their loved one would get upset when they left. Some families were more critical and would ask if they were unsure about what they were seeing and they would raise issues.

External monitoring

56. I might have the name wrong, but the Scottish Hospital Inspection and Advisory Service, or something like that, used to come in to carry out inspections. I remember it being a big thing when it was known they were coming.

57. Their inspection was assessing care, not the building, and it was after one of those inspections and a really critical report that I think the decision was made to close the hospital completely. There was concern about the residents and the care and support they were receiving and I believe the challenging behaviour ward was of particular concern.

Record-keeping

58. Notes were kept on the ward for each resident and there were also individual case files for each person, which would have their historical information. I think the case

files were kept elsewhere in the Medical Records building, which was partway up the hill.

59. My memory might not be entirely accurate, but I recall looking through case files as well as looking at people's essential lifestyle plans, which had been prepared by the Assessment Team. It was from the case files that I would get a sense of when people had come into contact with the system. I recall reading about people being removed from their family home at birth and parents being advised that it would be best that they walk away and have another child.

60. Discipline and punishment were not recorded in notes because it wasn't necessarily viewed in that way. What you would see is the amount of 'PRN' (*pro re nata*) medication that was administered, or you would see that someone had been put into isolation. You might see that they had had their privileges withdrawn, but it wasn't written as punishment, it was how their behaviour was managed.

61. Written through case notes, over and over again, you would see the words 'spontaneous aggression, no obvious triggers', for people who were seen to be challenging. I have actually written about this many times. Case notes were full of that phrase and that was used as a rationale and a justification for why people couldn't move out of hospital.

62. That tells you nothing about the person, other than that they have been repeatedly distressed. All it does tell you is that no-one has worked out why and no-one has worked out how to make sure it doesn't happen again.

63. My understanding is that medical records were retained by the health board when the hospital closed and at the end of decommissioning. Copies of any of the information that we had would go to the receiving social work department.

Review of care/placement

64. I'm not sure if there would have been any sort of review of a person's placement in the hospital. I think once you were in, you were in.

65. You could say a person's placement at Lennox Castle was voluntary, but what choice is there when parents are advised by everybody that they are best to walk away? If there is no other support, it isn't really voluntary. Families hold huge amounts of grief and guilt about the decisions that they made.

66. On the flip side of that, I am working with families now who have fought since the birth of their child to hold onto them. They are then castigated by the system for holding on tight and are categorised as problem families. They get blamed for taking the advice they are given and having their child placed in the hospital and they are blamed for fighting to keep them. There is so much judgement in our system it is extraordinary.

Discipline

67. Some wards were locked wards so that people couldn't leave. People would be moved into a locked ward if it was considered that their behaviour merited it. Sometimes people would be moved out of a locked ward because somebody else needed to be moved in.

68. A wonderful woman called [redacted] used to come up and see me. She had stomach ulcers and she knew that milk really helped her. She was feeling sore one time and she asked on the ward if she could get milk, but she was told there was none. Staff on the ward then sat down for a cup of tea and put a jug of milk on the table. Seeing this, [redacted] took a stick to the ward manager's car. If you regard the ward as her home, there was milk and so she wasn't wrong, however she was punished by being locked in the ward for weeks on end afterwards.

69. That seems like a small example, but every day, in every way, that sort of thing was commonplace. It didn't need to be intentional, it was the weft and weave of the place. Some people showed greater compassion, others less.

70. Confining someone to the ward as a means of disciplining them was quite common practice. Withdrawal of a resident's day-to-day requirements, as opposed to

privileges, was also used. Some were subjected to kind of ostracising too. A resident would know that they had been 'bad' and that they had transgressed.

71. There was a pervasive knowledge that things would happen if you didn't behave. People would experience physical restraint and, additionally, PRN would be used as required medication. Nursing staff, however, would determine when such medication was required, not the resident.

72. In addition to being locked in the ward, another means of discipline was to move the resident onto another ward. That might happen if their behaviour was seen to be either difficult for the ward to manage, or by way of punishment.

73. None of these measures would be recorded in the nursing notes as a means of punishment, however. They would be recorded as everyday management techniques. In some respects such treatment was seen more as routine, than out of the ordinary.

Running away

74. People did run away and, if they did, they would be brought back and confined to the ward or any of the other disciplinary responses referred to might be used.

Restraint

75. I didn't see anyone being physically restrained and given intra-muscular medication, but I would certainly say that some residents would believe that they were managed pharmacologically. People would tell you that they had been physically restrained, or that they had received PRN. Expressions that were fairly commonly used were "chemical cosh" and "you would get the jag".

76. You would see in people's records 'as required, intramuscular PRN prescribed' as a form of chemical restraint, and you would also see that people 'had to be removed and isolated'. You knew that would mean another form of restraint had been used.

77. There was almost a sense that what was written in the notes was some sort of justification of how difficult these people were. There are obviously different perceptions of what was recorded, though. There is only one person writing that history and what was being written doesn't involve the voice of the person. Such notes were, however, often used as a reason for why people should remain in the hospital and why they required the level of support they were receiving.

78. It wasn't my understanding that there would be a review of the use of restraint. It was more the case that the attitude was that the person was becoming more difficult.

79. We don't restrain people in C-Change, but we do hold a debrief. We have to learn what we could have done differently, because the responsibility is not on the person that we work for. We need to learn how we could do better next time.

80. I don't recollect there being such a process in the hospital, because if there were, the use of restraint would not have been so persistent for some people. Previously, the approaches that were used were those that would be used on psychiatric wards, although they were not necessarily textbook techniques. There was, however, an openness to try and learn and to do things differently.

Abuse at Lennox Castle Hospital

81. Abuse, physical, emotional or sexual, wouldn't be reported, it would come up in conversation. I think that the reason why it wasn't being reported was, in part, because the victim has to understand that whatever has happened is not normal. Instead, I would hear things spoken of in the passing, without significant weight or emphasis being given to what had happened.

82. People would relay to me about their standing naked waiting to have a bath or going into a bath after someone else had been in and that sort of thing. Others would talk about being made to sit in corners of rooms and of being isolated from other people. They would talk of being physically intimidated by both staff and other residents.

83. I heard of someone who was physically disabled being assisted with changing their incontinence wear and being injured in the process. Their legs were forced over their body so roughly that they suffered a fracture as a consequence.

84. I think it was important that I heard those conversations, but my role at that time was to look forward with the person and to try and consider how such things wouldn't happen again. The people who spoke to me about such things were not asking me to report them, what they really wanted was to be heard. With hindsight, you would reflect that such matters should have been reported, but at that time and place they were such a part of the institutional culture. It was remarkable in its awfulness, but it was routine. It was degradation, but it was just what happened.

85. I didn't see this, but it was fairly well known that some women, and some men, would exchange sexual favours for commodities, such as CDs, money or sweets. I heard of this happening between residents particularly, but I did hear without specifics of it happening between patients and staff.

86. One of the themes that came out during my research for my PhD thesis was that women themselves would tell me that the system they were within was the biggest risk to them. It wasn't a large study, but the two women talked about the vulnerability they felt, including with the other people they lived with. They both had been in Lennox Castle as children and both disclosed that they had been abused as children both before they had gone into care and in care, by both patients and staff. I think that was not uncommon.

87. I became aware of one particular incident of sexual assault during my time as a Commissioner, which I reported to my line manager. A male resident (B) had been raped by another male resident (A). Both had been on the ward long-term and both were young men at the time, however I can't recall what age they were. The incident had been clearly documented and I gathered information from the ward and from the notes.

88. This had happened at a time when there were still discussions ongoing about the hospital closing and this was another example of some of the things that went on,

about which there was incontrovertible evidence. While I was gathering information, I went back into the ward to get the ward notes because there was a concern that when we formally raised the incident, the notes might not be there. I had a good relationship with the ward manager and I took possession of the notes, however when the incident was formally raised that relationship cooled and became a little more adversarial.

89. After I reported it to my line manager, the incident was raised with the trust, but there was a closing of ranks and nothing more was really done. There was no thought of involving the police. Instead, the assailant (A) was moved out of the ward and onto a locked ward, but I think within a month or so he was moved back onto the original ward, where the person he had assaulted (B) still was. After the assault, the victim (B) largely confined himself to his bed. When he did get up, to go to the toilet etc., he would walk around the walls of the ward in what seemed to be an effort to protect himself.

90. I became aware of a further incident of abuse involving resident (B). A Christmas party was held in the Gallery, outwith the ward. I was told by the ward manager that everyone had attended. I was surprised, as I was aware (B) had been confining himself to his bed. I was advised that in order to get him to the party, ward staff had thrown a blanket over his head and bundled him out of the ward. I surmised this was so that all staff members could attend the party. Had (B) stayed on the ward, a staff member would have had to remain with him. I can only imagine how terrified (B) must have been.

91. I had been working with an organisation to support both young men to move out and it was decided that the resident who had been assaulted (B) needed to be helped to get out as quickly as possible.

Reporting of abuse

92. I felt it would be very hard for someone to raise issues, seek change, or raise grievances. Certainly on paper, there was a complaints procedure for families and residents, but I was someone with an outside status and from my experience I found

it very hard. We Commissioners weren't aware of many complaints, but those we were aware of were often from people like student nurses, who came in from outside.

93. The barriers to abuse being reported by residents included understanding what was happening to them was wrong. It may feel wrong, but if it is happening to other people, or if no-one else is reinforcing or supporting the feeling that it is wrong, that is the first challenge.

94. Another challenge is the ability of some disabled people to communicate their feelings. You are even more vulnerable if you haven't got the language to communicate. There were OT (Occupational Therapy) services for some people and there was speech and language therapy involvement, but it was often inconsistently supported. Some people, for example, had hearing impairments, but didn't have people who could sign working with them. Others had visual impairments but had no accessible information. Instead, people just made do.

95. Another barrier to abuse being reported is that even if you do speak up nobody hears you or does anything about it. Or, if you do speak up and something is done about it, it then gets undone again. In speaking up, you have gone through all that you needed to do, you have voiced your concerns and yet things have just gone back to how they were before. It is called institutional drift.

Attitudes towards the closure of Lennox Castle Hospital

96. There were different levels of acceptance of the fact that the hospital was closing. One ward in particular was very against any of their residents leaving. There was a protectiveness and some staff were more resentful and resistant, even oppositional, whereas others were more accepting. It was an unusual arrangement, because there were cultures that had existed on the wards and then we were creating a different dynamic. We were like a pebble in a pond, causing ripples.

97. To be fair on the staff, many of whom were good people, there was a lot of uncertainty amongst them. They had chosen to work in this place and now it was closing and they didn't know what it would mean. Generations of families had worked at Lennox Castle

and it was a big disruption. It was quite a closed employment environment and it was largely still staffed by those who lived in the community. You had to be really careful what you might say and who you were talking to, because it might be someone's cousin.

98. Staff of the Trust and the Commissioning Team had their offices at opposite ends of the gallery building, with a kitchen in between. We would meet in the kitchen and it could be a little awkward occasionally, which was part of the tension of working there.

99. It wasn't just staff who were resisting the hospital closing, not all families embraced the idea. There was a group of families called 'The Friends of Lennox Castle', who fought to keep the hospital open because they were so scared of what closing it would mean for their loved ones. Previously, they had been told that it was the right thing for their loved ones to be kept in the hospital and now they were being told that their loved ones could live in the community. Some families were beside themselves with what we were doing. We were not popular.

C-Change

100. At C-Change we design support around each person alongside multi-agency teams. We feel that our specific contribution is to protect the person from the odd stuff that the system does to them. A judge once stated, "what is the point of making people safe if we make them miserable?" Sometimes, in our efforts to keep people safe, we actually make people miserable and miserable people will show you their upset and distress.

101. We would plan a resident's move with the new provider. This would be overseen by a multi-agency team. A support plan would be reviewed at the pre-discharge meeting to ensure that all predictable risks were considered and the support was available to ensure that the person remain in their new home. Unfortunately, despite this work, some people returned to hospital because the provider decided to withdraw support based on some behaviour that had been presented. This may have been that the person became upset and was verbally or physically aggressive. In one instance the person had been left without direct support and had climbed out of and then fallen

from a first-floor window, injuring themself and requiring emergency hospitalisation. They were subsequently readmitted to the long stay hospital.

102. There is lots of research showing that if we listen to people better, if we try harder not to treat people in certain ways and if we don't try and manage them, people will respond much better. We need to listen to people and work out how to alleviate their stress. We need to ensure that they live happier lives and then maybe people wouldn't have to try so hard to say that they are hurting. They wouldn't have to fight so hard, either physically or verbally, if we try to let them live more contented lives. This was not revolutionary, it was just humane.

103. We were trying to use the same amount of money that the state would have used to design a life for a person in an ordinary setting, in their own home. When often the answer to dealing with aggression is five-to-one support for somebody and when you know that such support refers to the number of people required to restrain that person, you could instead ask how that money could be used to allow the person to live a life of peace and comfort.

104. Often, you have to move from viewing a person in a particular way to understanding what that peace and comfort means for them. You need to respect the things that might not seem important to you, but which are incredibly important to that person.

105. It is all about understanding that each individual has bespoke needs, rather than trying to fit a standard response around them. In every way it is about designing the support around what that person needs, from their home to the people who work with them and matching the people who work with them.

106. Quite often we might be told that a certain individual needed big men working with them, but if you are someone who has lived a life of trauma, you know what those people are there for. If we instead actually listen to what the person is trying to tell us, if we look and see who they gravitate towards, who they feel more comfortable with, we often find they do not want burly men around them. They might respond better to a quieter, gentler approach. They might appreciate being taken away and being allowed to be upset.

107. I often say that you do not want to be judged on your worst day and yet we carry a person's history around with them and we design their whole lives around their worst day. It is not reasonable.

108. Usually, the cost of such bespoke support is comparable to what had been spent previously, but after a time it costs less. We have a social care system predicated on the idea that people want as much as they can get, but in reality, nobody actually wants more than they need. Nobody wants more people around them than they need, they just want enough to live a good life.

109. At C-Change we have never supported anyone with five people, even though the recommendation has been that some person has five people. Those five people have a specific purpose and we just don't do that. We have supported people with three staff, but that was an arrangement made to get that person out of an institution, because other people's anxieties were saying we must have that number. That did not make sense for the person, however, and, with multi-agency agreement, that changed over time. The person being supported should be driving the support they get and we need to be listening to them better and changing their support in a way that makes sense for them.

110. C-Change are proactive on the responsibilities of risk, which was the subject of my PhD and which required the ability to articulate risk and to be creative and understanding. If you are working with people who live and work in one establishment, you have to acknowledge their view of the world and what is possible. You have to meet them there, but not compromise on what the person wants. It is a case of working alongside people and addressing the concerns they have, recognising the legitimacy of those concerns, but suggesting alternative approaches.

111. No-one in Lennox Castle Hospital ever had access to a kitchen, so there were huge concerns amongst hospital staff about someone having access to one in their own home. We had to then work with the hospital staff to show how someone could safely access a kitchen. That might mean having some sort of middle ground for a while as the person learned how to safely use a kitchen. It was not a case of being cavalier,

we needed to accept that someone should be able to live in their own home and have access to their kitchen.

112. That was a big part of the work that C-Change did. We were trying to hold onto that human rights-based thinking: a person's rights to a home and their right to make choices, sometimes good choices, sometimes not. That was culturally so different to an institution.

Resettlement

113. Although our aim had been to support people into ordinary living, we absolutely did not manage that. Generally people moved out to group homes no bigger than four, although there were some exceptions where people had flats within a building. A lot of that was driven by whatever housing was available and 'Homelink' was set up with a group of people who had housing expertise. They helped us get housing and that made a huge difference, enabling us to get properties from housing associations.

114. More of an effort was made to tailor the support residents received when they were to be moved out of the hospital. A greater focus could be put on supporting people to develop their communication skills when they were no longer living on a large ward. There was a sense, though, that some staff felt that because the hospital was to close, there was little point in investing too much time in someone until they were due to move out.

115. The thinking around the essential lifestyle plans that the Assessment Team prepared was very good. It wasn't the case that the plans were just medical chronologies. There was a difficulty, however, in asking an institutionalised resident what their wishes were, in a place where they have such limited information as to what a good life could potentially look like. We used to get quite a lot of lists of what people liked to eat, but those lists were largely determined by what they were served in the hospital.

116. You need to start somewhere with people believing that they are going to be listened to. Something that hadn't really happened previously. I remember having ridiculous conversations such as asking someone what kind of house they might want to live in,

when they had never before lived in any sort of house. Instead, what we needed to do was show people wallpaper books and ask them what they might like in their own house. They might choose a paper with elephants on it, but they can be given that and, if they see the elephants on the wall and decide they don't like them, the wallpaper can be changed. The idea that they actually get to choose something and then they see it, is really important.

117. A lady who had a visual impairment said she wanted a red door for her house. We made sure she got that red door because, even if something might have seemed to some people to have been irrational, if it was important to her, it was important. We couldn't always do it, but, because people had previously had so little choice, we did our best.

118. Our approach was really obvious when people moved, because in an astoundingly short period sometimes, you would see people become themselves. You would see them take a step towards the person they could be and families saw that too.

119. We had a review a month after someone had left Lennox Castle and I would go out and see people living in their homes. I just loved that part of my job. I was always blown away with the human spirit. We had good providers working with people and generally good staff working with individuals and even in such a short space of time you would see a change in people.

120. An example was a lady who had been in Lennox Castle since she was a child and whose nieces were determined she was not going to move out of the hospital. The nieces used to come and visit her religiously and bring her stuff like sweets and juice and that sort of thing. When they did, their aunt would take the bag and wander off and that would be it. She was a woman of very few words.

121. I had a meeting with the nieces that turned into one of the most unpleasant meetings I have ever had. They were furious that I was insistent their aunt was moving and that the ward had to close. They complained about me to their councillor and their M.P. and to anyone else they could.

122. Their aunt moved out with another woman on the ward, who was her friend, and I went to visit them both in their home for the four-week review. The nieces were there and I was expecting to get more of the same, but they actually apologised to me. They told me they had gone to her house and she had invited them in and that she was then part of making them a cup of tea. She spoke to them and she told them that she had gone to the hairdresser and that she had got her nails done. She spoke to them because she had things to say to them. She was able to speak of things that she had actually experienced.

123. She was supported by some lovely people from the ward, who chose to continue to work with her after she left the hospital. They also spoke about realising that they didn't know who she was. What things she liked to do, what music she liked.

124. Those two ladies ended up living separately, but that was because they had discovered they liked different things. One of them liked sitting watching westerns on the TV and eating chocolate and the other wanted to go out and explore the world. A world which was now her oyster.

125. Not everyone went on to do great things, but once they moved out of the hospital, people were able to live a life more of their own rhythm and at their own tempo. A life of their choices. That, at the very least, is what they should expect.

126. A man in his eighties was moved out with his pal into the east end of Glasgow. He had been in the hospital since he was thirteen, after he had been dropped off by his dad when his mum had died. The man was supposedly slow in school but he was actually deaf. He moved into a flat near his nephew and when I went to see him for his review, he was sitting in this big chair in his livingroom, with the telly on. He looked like he had lived there all his days. I can't guarantee that was the case for everybody, but that was what I saw. People are extraordinary.

127. It is almost hard for some people to grasp the idea that, for some of the residents, the thought of moving out of the hospital was terrifying, however a significant number of them had been in since childhood. There was one gentleman who had been in hospital

since birth and who knew I was involved in closing the hospital. Every time he saw me, he burst into tears.

128. He had extraordinary resilience, but he had no perception of what another life could look like and I was the most terrifying thing for him. Life in the hospital was all he had ever known and he had managed to make something of it. He had known and connected with lots of people. He would run errands and do things for people and he had managed to establish one of the strongest senses of community in the hospital.

129. We had to get a special agreement to have someone work with him for almost a year before he would even contemplate moving. We wanted him to develop a relationship with somebody and experience the world outside the hospital enough so that he was able to contemplate moving.

130. He had a very noticeable physical disability, a facial characteristic, and therefore it was really important that he became known and connected with other people. He ended up moving into a flat in Kirkintilloch where there was a real sense of community. He moved in with a flatmate who provided consistent support to him, together with other members of a team who provided additional support.

131. He was a genuinely brilliant man, who had very limited speech, but who had extraordinary communication and charisma. He became connected, known and valued within his community, much to the benefit of that community. He had a series of different flatmates who supported him along with a team of people who really cared about him. The flatmates would, in exchange for rent-free accommodation, provide a consistency of support, albeit they had their own lives as well. The idea was that the gentleman wasn't surrounded completely by paid support but that he was assisted in achieving a sense of how to build a home and community.

132. This wasn't a unique approach to supporting people, but it was a novel one. There is a bit of an assumption that disabled people want to live with other disabled people, or that a disabled person might not want to live on their own. That is just not the case and is discriminatory thinking in itself. The important point is that if it is your property,

if it is your social capital that you use to attract people into your life, then you should be able to choose. Shared care is now based on that notion.

Police investigations/criminal proceedings

133. I have never given a statement about my involvement with Lennox Castle before and I am not aware of any police investigations there may have been.

Lennox Castle Stories

134. In 2012, C-Change along with 'Project Ability' conducted a social history project entitled 'Lennox Castle stories'.

135. I worry about us forgetting about the institutions. I thought that when we closed Lennox Castle Hospital no families would ever again be faced with such a place being the only option when things got tough for them, however I think I had been a little naïve. Private hospitals are now popping up all over the place and people are going to them instead. Our knowledge and understanding of what these institutions were like needs to be clear and on the record. The people who lived in these institutions are dying and therefore it is easy to look back and forget what the reality was.

136. The idea behind Lennox Castle Stories was the desire to capture those people's stories, lest we forget. C-Change worked with Project Ability because they brought a creative, artistic, input. We thought that straightforward interview and narration might not work for everyone, but that we needed to approach allowing people to tell of their experiences in whatever way worked best for them. We wanted people who had lived there, their families and also people who had worked in Lennox Castle to speak of their experiences.

137. We put a call out through networks to anyone who wanted to be involved and people came and told their stories and then were involved in saying what they were happy to share. We wanted them to have a sense of ownership, rather than it being a mission or a message. It was their story and they only need share the bits they wanted to.

138. They were able to create artwork and do drawings and there were some video interviews as well. Those that participated in the video interviews were those who wanted to do so and who were happy for their information to be shared. Some people participated in the project but didn't want their participation to be public.

139. Many who participated had been in Lennox Castle since childhood, however it is not easy to talk specifically about children's experiences, because there is no clear demarcation of age in such institutions. I'm not sure many had such a clear distinction between being a child and being an adult and, in any case, when does someone's childhood start and stop?

140. There had been children's wards at Lennox Castle, but the markers that we have of our progress through life are, I think, different when you live in an institution. You might not know how old you are and a marker might be when you moved ward, rather than when you had a particular birthday, for example. Children in institutions such as Lennox Castle weren't afforded those landmarks and I am not sure the way we treated them accorded with any notion of childhood in any event.

141. We frame things in a certain way because we have all sorts of rituals and reinforcers of a pattern. One of the other notable issues, however, is that people left Lennox Castle with no photos of birthdays, Christmases, or other significant times. All some would leave with was a black bag of clothes.

142. Some people lost their names in the hospital on occasion. They would move ward and you'd see when you track through their records that they were given another name because there might have been another two people on the new ward with the same name. That is why, as an organisation, C-Change tried to capture their stories.

Lessons to be learned

143. As part of the closure of Lennox Castle, after I had set up C-Change and when I was no longer working as a Commissioner, we set up a project called the 'Robust Services Project'. We were working with a group of people who had reputations for being challenging and this was a collaboration between the trust and three provider

organisations who were all going to be involved in this work. We worked together to share ideas, thoughts, policies and practices. The idea was that, if the receiving wards' practices were more similar, people that were being admitted to the hospital would come out more quickly.

144. One of the things we looked at was restraint and how we dealt with instances of behaviours that might be difficult. As an organisation at that time, we used 'C.A.L.M.' techniques, which is Crisis, Aggression and Limitation Management. It was all about de-escalation and trying to avoid getting into the situation in the first place. As part of the project we would come together and share what we did. A trainer from the trust came and spoke about how the trust did it and our trainer came and spoke too. After that, the trust adopted C.A.L.M. approaches.

145. One of the issues historically is the idea of perpetual children, that people with learning disabilities are infantilised. There is a disability advocate, who is dead now, called Dave Hingsburger and we drew on his work 'The ethics of touch', which is about how we physically support people. In our overhandling of people, we transgress bodily autonomy and that in and of itself can make it harder for people to understand and hold to boundaries around physical interaction.

146. We do all sorts of strange things in 'service land'. We have no touch policies, but what does a no touch policy actually mean? Does it mean that we should be safe in touching people, but within boundaries? In some respects we transgress. We touch people without asking permission when we're attending to their personal care. We create all sorts of strange dynamics that, in some respects, actually make people more vulnerable because they're not being honest. There are all sorts of mixed messages.

147. We so struggle to navigate it, we go to one or the other. If you are a physically disabled child who requires assistance, that assistance is all very routine and is professionalised, but then we say that we can't hug that child.

148. I think children and adults get lost in such policies because they are at best confusing. It makes sense if you are only looking at preventing abuse, but not if you are looking at nurturing and a caring touch. If you are lacking transparency you end up with mixed

messages and the difficulty becomes identifying what is abuse and what is not. It adds to the vulnerability that we are purportedly trying to protect children, or adults, from.

149. At C-Change we did some work around that and we have developed a relationships and sexuality policy. We worked as part of a consortium to try and really think through how we can protect people's rights and protect their safety and their well-being.

150. We weren't just dealing with Lennox Castle when we were closing it, we were helping people who were also funded by Greater Glasgow Health Board move from other institutions. People were often scattered around. Oddly, if a consultant had an interest in a particular condition, people would be clustered. The commonality in all of the institutions I was involved with was dehumanisation. People's identity as a person of worth was lost and instead they were categorised and defined by somebody else's view.

151. You go into places such as Lennox Castle as an individual, but you become, in a sense, homogenised. We wrap all sorts of things round people, we use all sorts of language labels, but we lose the person. Your individuality gets lost and the who you are is less clearly defined the longer you are in. You are viewed through a different lens and it is that lens which describes who you are. The chronology that is contained in nursing notes describes incidents and accidents, ward moves and all that sort of thing. It is black and white, there is no colour. There is no flavour.

152. All that is important, but if you were to sit around a table with ten people and discuss that person and if you were to ask what that person's favourite music was and nobody could tell you, then you don't know the person. You know someone else's facsimile of that person, but the job must be to find out who that person is.

153. Most often, although it depends how long the person has been in hospital, the family will hold the kernel of who they are and that is where you start to try and earn trust. The fundamental belief must be that nobody who comes out of hospital owes us anything in terms of their behaviour. Why should they trust us? We must listen to the family and we have to earn their trust every time. We always have to be looking to do better.

154. Although this particular woman hadn't been in Lennox Castle, when we started working with her, she had no bed. It had been given away because she didn't sleep in a bed. The hospital staff said she was deaf and when we saw her, she was like an ammonite, curled on the floor. She had a suit on that was buckled up the back because she self-harmed to the degree that she [redacted] and, in doing so, she experienced significant [redacted] damage. As a result of this behaviour, she was required to wear the body suit to prevent her gaining access to herself. At the time of her discharge there was no rationale given for her self-harm. Only later was she diagnosed with endometriosis. She did not use words to communicate. It is thought, by those who knew and cared for her, that pain associated with this condition may have contributed to her behaviour.

155. We started working with her and we discovered that she wasn't deaf and that she actually quite liked men. She moved into her own house near her niece and, because she never did like lying in a bed really, she got a pull-down bed in her front room. We got her good health support for her endometriosis and she had a team who loved her dearly. She loved warm holidays and there are wonderful pictures of her being supported to walk along the beach.

156. That is what can happen if you just listen. Everything we had been told about this woman just wasn't right, but that is what institutions do. She passed away last year and there was a glorious celebration of her life. It is not so hard.

157. As an example of just how deep trauma runs, we supported a former resident for twenty-odd years until, at one point, he began to get upset. We couldn't figure out what it was until we realised that the community nurse who was coming in had been a nurse in Lennox Castle. As soon as he saw this nurse it was his profound fear that he was going to go back there. He felt unsafe and so we had to ensure another nurse was sent.

158. Our first thought had to be that it was not him, it had to be something else and track back to what had changed. Mistakes occur when the first thought is what is wrong with the person. We do that and then we start thinking whether we need to get a

psychiatrist in, or whatever. It is both simple and it is complicated. The onus to do better doesn't sit with the person, it sits with us. Unfortunately our system is not based on that premise.

Further Information

159. 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]……………………………………

05 July 2024
Dated………………………………………………………………………………