

1

Wednesday, 11 June 2025

2

(10.00 am)

3

LADY SMITH: Good morning, and welcome to the last day in

4

this block of our hearings in which we're looking into

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the provision of residential care for children with

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healthcare needs, additional support needs and disabled

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children.

8

Now, this morning, we move to two people who are

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coming from Fife Council, I think; is that right,

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Ms Innes?

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MS INNES: That's correct, my Lady.

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We have two witnesses, James Ross, who is Head of

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Service for Children and Family Social Work and the

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Chief Social Work Officer.

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I understand that James has given evidence to the

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Inquiry before, albeit when he was working at Dundee

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City Council, so he appears in a different role now.

18

The other witness is Maria Lloyd, who is the Head of

19

Service for Education at Fife Council.

20

LADY SMITH: Thank you.

21

James Ross (sworn)

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Maria Lloyd (sworn)

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LADY SMITH: James, welcome back.

24

MR ROSS: Thanks.

25

LADY SMITH: I gather you've moved but geographically not

1 that far away from your previous role.

2 MR ROSS: That's right.

3 LADY SMITH: You know how we work here and I hope I don't
4 need to explain that to you again.

5 Maria, I am conscious of the fact we've got quite
6 a lot of questions to ask both of you about Fife this
7 morning and it might spill into this afternoon. We'll
8 see how we go.

9 But you've got some documents in front of you. You
10 will see more documents coming up on screen. If you've
11 got any questions at any time, or you think we should be
12 asking questions that we're not asking, do speak up
13 about that.

14 So far as breaks are concerned, I normally run from
15 now until about 11.30 before we have a morning break and
16 then return to do another session before lunchtime. But
17 if either of you needs a breather before then, please do
18 say, or if you need anything else, any other
19 difficulties or problems, just speak up.

20 The key is that I want to help you get through your
21 evidence for us as comfortably as you can, so that,
22 between us, we can produce the best record of the oral
23 evidence that you have to offer.

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

1 Ms Innes.

2 Questions by Ms Innes

3 MS INNES: Thank you my Lady. Good morning.

4 Maria, if I can perhaps start with you. You've
5 provided a copy of your CV to the Inquiry and we know
6 that you're currently Head of Service of the Education
7 Function of Fife Council and you've been in that role
8 since September 2019.

9 MS LLOYD: That's correct.

10 MS INNES: You tell us in your CV that your background is in
11 teaching and you've held various teaching roles
12 throughout your career before moving to work in
13 different roles leading to your current role.

14 We do see that you were a Quality Improvement
15 Manager for Special Schools in the City of Edinburgh
16 from August 2015 until August 2017?

17 MS LLOYD: That's correct, yes.

18 MS INNES: And that's particularly relevant to the type of
19 setting that we're looking at in this case study, which
20 is why I highlight it.

21 James, as we know, you've given evidence to the
22 Inquiry before. We can see that you've actually worked
23 with Fife Council for quite some time in different roles
24 with children and family social work and you spent,
25 I think, a year at Dundee City Council as a Senior

1 Service Manager, but you returned to Fife in May of last
2 year, to take up your current role as Head of Service
3 for Children and Families and Chief Social Work Officer;
4 is that right?

5 MR ROSS: That's correct.

6 MS INNES: We're going to look at various settings which
7 were under the -- or managed by Fife Council and the
8 first of those is Ovenstone, and if we could look please
9 at FIC.001.001.6261 and if we move to page 2 of this
10 document.

11 This is the response of the council to a notice
12 served by the Inquiry in respect of
13 Ovenstone Residential School, and I think we can see
14 here that a team essentially put together the response
15 to this notice, and I assume that neither of you were
16 involved in the preparation of this response.

17 MR ROSS: That's correct, we weren't involved.

18 MS LLOYD: Yep, not involved in it.

19 MS INNES: Prior to giving evidence today, I think you've
20 been able to review the response; is that right?

21 MR ROSS: Yes.

22 MS LLOYD: Yes.

23 MS INNES: If we can look, please, at page 6 of this, this
24 tells us a bit about how the residential school at
25 Ovenstone came to be.

1 At the bottom of the page, it tells us that before
2 it became a school, it was a hospital, historically, for
3 the treatment of infectious diseases up until 12 July
4 1947, and thereafter it was a convalescent home for
5 children for a period; is that right?

6 MS LLOYD: Yes, that's correct.

7 MS INNES: And then there's reference to children being
8 placed there in the period, in the late 1940s
9 essentially.

10 If we move on, over the page, to page 7, it tells
11 us, at the top of the page, that from 1947, until 1974,
12 it was initially termed as a convalescent home, then as
13 a psychiatric unit and administered under the health
14 function of the local authority; is that right?

15 MS LLOYD: Yes, that's correct.

16 MS INNES: So although local authorities, as we understand
17 it, don't have these functions now, it appears that it
18 was under the responsibility of Fife Council up until
19 1974?

20 MS LLOYD: I think it was Fife regional area rather than
21 Fife Council. I think it was bigger than Fife Council
22 currently is.

23 MS INNES: Because that would have been the time when it was
24 Fife County Council.

25 MS LLOYD: That's correct.

1 MS INNES: The response goes on to refer to some records
2 that were found there.

3 Towards the bottom of the page, there's a paragraph
4 beginning:

5 'In the 1969 annual report for the county council,
6 the unit was referred to as Ovenstone Psychiatric Unit.
7 It had places for 15 children being treated for various
8 problems ranging from school refusal to aggressive
9 behaviour.'

10 And then it refers to the 1971 annual report, where
11 it refers to the unit saying that it:

12 'Continues to function as a residential school for
13 children with behaviour problems, whether due to
14 themselves or the home environment.'

15 Then there's reference to the matron reaching
16 retirement age.

17 Now, that seems to conflate a number of different
18 ideas in terms of what the unit was doing. It was
19 a psychiatric unit, but it was also a residential school
20 prior to 1974.

21 Are you able to shed any light on that or is that
22 just a confusion that arises from the material that's
23 available?

24 MS LLOYD: I think we've only read what's in the report,
25 counsel, so we're not any clearer on it either.

1 MS INNES: If we go on over the page, to page 8, there's
2 a paragraph beginning:
3 'From 1974 it became a residential school
4 administered by the Education Department. It is
5 explained in an article about special education in
6 a magazine for Fife teachers dated June 1974. The
7 Ovenstone unit is a residential accommodation for
8 a small number of maladjusted children of primary school
9 age.'
10 And then it says:
11 'Until the new area Health Board came into being on
12 1 April this year, Ovenstone was the responsibility of
13 the School Health Service, but is now in the process of
14 coming under the direct control of the Director of
15 Education.'
16 So, again, there seems to have been a reorganisation
17 in 1974, but it looks like Fife Council had some
18 responsibility for it prior to that change.
19 MS LLOYD: That's our understanding as well.
20 MS INNES: Now, it refers to 'maladjusted children'. Do you
21 have any understanding of what that term means?
22 MR ROSS: I suppose what we would describe it now as
23 children who are affected by traumatic events that are
24 then displayed in their behaviour. So I think the
25 language at the time was the language at the time to

1 describe what we would now see as trauma in children and
2 young people.

3 MS INNES: And then if -- sorry --

4 LADY SMITH: I just wonder, was it really being that
5 specific or was it an approach that started from an
6 assumption of a norm to which all children should
7 conform and if they're not conforming to that norm, then
8 they must have failed to adjust to the norm and
9 therefore they are 'mal', as in badly adjusted?

10 MR ROSS: I think that's right and I think when you see,
11 even in the A to D response, the fact that we felt that
12 young people require psychiatric care, I think just --
13 I think, reinforces that message. So I think for
14 children and young people who weren't conforming to
15 adults and the expectations of adults, then they were --
16 they were labelled and sometimes - at times, treated and
17 cared for in a particular way.

18 LADY SMITH: And perhaps reflects that rather strange
19 comment in the 1969 report that we looked at a moment
20 ago, that we're talking about providing for children
21 with behaviour problems, which could be due to
22 themselves, their fault, their failure to adjust to the
23 norm or the home environment.

24 So the home environment having had such an effect on
25 them that they failed to adjust to what is the perceived

1 norm.

2 MR ROSS: And I think that, for me, kind of, just to

3 collectively review the A to D responses, what you would

4 glean from that is that there was a perception by adults

5 who cared for these young people that they were in

6 control of their own behaviour and as a consequence of

7 not behaving, then that was a choice on their part and

8 adults behaved in a particular way to respond to that

9 distressed behaviour. So I think, you know, when we,

10 kind of, look at all of the documentation that we've

11 submitted to the Inquiry, that's a running thread

12 throughout the A to D responses.

13 LADY SMITH: And a child is a bad or naughty child if they

14 aren't fitting the style of child, the norm of child,

15 that society was expecting because it's easiest for

16 adults if they behave like that. That was the reality,

17 wasn't it?

18 MR ROSS: Yes.

19 MS LLOYD: I think it also comes through that the way in

20 which the process for admitting the children and young

21 people into Ovenstone. You know, there was no real

22 clarity round about it and it seemed to change as it

23 went through time. So I think your summary is very

24 clear and accurate.

25 LADY SMITH: Thank you. Ms Innes.

1 MS INNES: Thank you, my Lady.

2 If we can look at page 9 of this document, at the
3 top of the page, in the second sentence there, it says:

4 'From 1974 until its closure, Ovenstone functioned
5 as a residential school and was managed by Fife
6 Education Department. Ovenstone School was closed in
7 1998 because of a change of policy to community-based
8 care for children.'

9 Now, we know that all three establishments that
10 we're looking at closed, essentially, all round about
11 the same time. Are you able to tell us a bit more about
12 what the change of policy was and how that affected
13 these establishments?

14 MR ROSS: I'm happy to, kind of, give just some information.

15 I think the report that led to the closure of these
16 larger institutions was rooted on the basis that, you
17 know, dysregulated children or children who have complex
18 trauma do better in smaller settings and have the care,
19 nurture and attention that they need to have reparative
20 care to overcome that adversity, so the council's, you
21 know, plan at that point was to move away from large
22 residential schools to community houses, and that has
23 been what we have delivered to date.

24 MS INNES: Maria, I don't know if you want to comment on the
25 sort of the -- I suppose the presumption of mainstream

1 school and the separation of the care of children who
2 require residential care from their education?

3 MS LLOYD: So if I could just comment on your previous
4 question as well, counsel. Obviously, the closure of
5 the three homes came about after a 1997 report that
6 outlined they were looking at the role of each of the
7 services, its function and what the young people thought
8 of the function of that. So out of that came the fact
9 that really the three homes needed to close, because
10 they weren't actually serving the right purpose. So
11 I think that came out really clearly from the 1997
12 report, sorry.

13 MS INNES: No, that's fine.

14 And then my supplementary question to that is
15 a broader question, which is: your view on the
16 separation of the schooling or education of children who
17 require residential care.

18 MS LLOYD: From reading the witness statements through this
19 Inquiry, in particular, I think it became very clear and
20 very obvious, the impact of not having good education
21 had on the children and young people in these homes, and
22 the victims themselves have commented on the importance
23 of education and the impact it had on their lives and
24 wanted to access mainstream schooling to mix with their
25 peers, who were age and stage appropriate, et cetera,

1 because, obviously, in the homes there was a mix of ages
2 and experience there.

3 So it's very important to me in education that young
4 people get the right access to education, because we all
5 know that anyone who is trauma-informed, it's more
6 difficult for them to succeed. So my opinion on that is
7 it's better to access mainstream education and, by that,
8 I mean a separate sort of education.

9 I think for a number of reasons that certainly my
10 colleague and I have discussed, which also gives you
11 more access to other key staff that you perhaps might
12 feel more able to go and disclose to in a safer
13 environment because there's more people, it saves
14 dominance of maybe one or a few adults in any
15 environment also.

16 So, for me, there's the bit of the care and the
17 pastoral support and they've been able to go to someone,
18 but there's also the aspect of getting a better
19 education, because, obviously, in the schools there are
20 a range of teachers, a range of subjects and what came
21 across to me in some of the reading of this is there was
22 quite limited education experiences in some of the homes
23 and I know we're speaking about Ovenstone in particular.
24 I don't know what the curriculum was there, but it would
25 be quite limited, and my experience of special education

1 is it can be quite limited because of the numbers and
2 the experience of teachers within that setting.

3 MS INNES: James, do you have any comment on that broader
4 question of the separation of the care and education of
5 children?

6 MR ROSS: Yeah. I think there's a number of things to
7 reflect on when you remove children from their family or
8 a decision is made that they should be placed elsewhere,
9 the loss that comes is significant and then to have that
10 disrupted education experience where you may lose your
11 peer associations, the relationships with staff, but
12 it's also very stigmatising that your complex trauma,
13 that does, in itself, lead to disruptive behaviour, that
14 that has to be addressed in a very different way. So
15 I think we've moved away from trying to have care and
16 education as one and trying to separate that out.

17 And I also think that for children, often where
18 they've had a difficult education experience, we have to
19 be clear that how that's managed is managed with their
20 education and you can see the spill-out of the
21 consequences or the sanctions from a difficult education
22 into care and I think the blend of care and education in
23 itself can be consequential.

24 There's little chance for children and young people
25 to have that separation and escape from what can be

1 an intense environment, but I think also we lose the
2 ambition for young people. Maria's right, the
3 opportunity to succeed comes in with a broad range of
4 curriculum and opportunities and to be around other
5 young people that might help your regulation, who are
6 less dysregulated, is hugely important and my experience
7 of residential school settings is that children who are
8 dysregulated can often further compound each other's
9 difficulties. So therefore the education that's already
10 limited, in itself may become even more limited because
11 of the demands that that group might pose together. So
12 I think there's nothing but positives to move away from
13 that type of delivery of care and education.

14 But I think we would all want to acknowledge that
15 our ambitions for looked-after children educationally
16 are still low and we've still some way to go in order to
17 make those improvements.

18 LADY SMITH: And, of course, one of the major problems,
19 certainly we've seen in the evidence, is you may have
20 a child who just will not attend mainstream school. The
21 reason they are taken and put in a residential facility,
22 or were taken and put in a residential facility, was
23 because they were not attending for various reasons.

24 Am I right in saying that the way you're looking at
25 it is that, first up, try to get them back in to the

1 mainstream school.

2 Now, you thought about the child who, when they're
3 taken away, is losing the stability, if you like, of
4 teachers and friends and so on, but, of course, we've
5 seen a lot of people who weren't that sort of child
6 because they hadn't established a school life at all.
7 So you've got to get them used to the habit of the
8 school life, the people that are there, before you can
9 even start educating them in mainstream; is that right?

10 MR ROSS: Yeah, and I think the whole issues around
11 conformity and that we provide an education provision
12 and that children should and must attend whatever adults
13 decide is the right education for them, and I think --
14 and we see, even from the children's hearing system,
15 children were accommodated away from the parents because
16 of non-school attendance and there's still the ability
17 to apply a measure on an order that children should
18 attend school, as if the order, in itself, will make the
19 difference.

20 It's the provision, it's the skill-set of
21 education -- particularly educational psychology, to
22 understand the barriers to access an education and to
23 begin to create an education provision that a young
24 person feels they can access and engage, and I think
25 also, at times, we are very condemning of parents. At

1 times, we could be a very -- it could be an excellent
2 parent, a very effective parent and still not get your
3 child to school, and we made assumptions that the
4 children who didn't attend school, it was a failing on
5 their parents' behalf, and I think that's a simplistic
6 view to take.

7 LADY SMITH: Ms Innes.

8 MS INNES: Thank you.

9 You mentioned there about -- in your evidence
10 a moment ago, about sanctions spilling over from the day
11 at school into the care setting and I think you're
12 perhaps referring to things like people not being able
13 to do activities because of a behavioural issue that had
14 arisen during the day. I think -- is that sort of thing
15 that you're meaning, James?

16 MR ROSS: Yeah, and I think also what you find is that the
17 staff that worked within the school setting might also
18 be the care staff in the evenings, so there's not that
19 separation of discussion, there's that continued
20 reinforcement of their behaviour earlier in the day, and
21 I think just the impact that has on a young person's
22 self-worth and how that -- that behaviour of staff, who
23 have been in both settings, that reinforces negativity
24 and I think what we see is sometimes spiralling
25 behaviour of young people as a consequence of the

1 approach from staff. So I think that separation is
2 helpful, one in terms of the consequences, the sanctions
3 being, you know, grounded, no access to activities, but
4 also just that message that comes from your school day
5 into your evening care, which is you've had a really bad
6 day and you've not behaved and there's no escape for
7 young people from that.

8 And if you live in your average family home, school
9 will have addressed that, there will have been a
10 conversation with a parent, but it doesn't -- that
11 narrative doesn't follow you the same way and I think
12 for a lot of our looked-after children, historically
13 and, at times, currently, there is a lot of attention
14 paid to behaviour and a lot of language used to young
15 people. So if they do something and there's an error or
16 there's a mistake, there is an opportunity to discuss
17 that, repair from that now and leave it, but
18 historically that wasn't the practice of the day.

19 MS INNES: If we look on, please, to page 21 in this
20 document, we can see some information about the ethos
21 and functions of Ovenstone and it tells us that it's
22 a small residential facility with all of the pupils, it
23 says there, being day attenders, who have been referred
24 by primary schools in Fife. Although I think we know
25 that children were obviously staying there as well as

1 attending school during the day.

2 The paragraph beginning:

3 'The overall philosophy at Ovenstone may be simply
4 described as that which entails the carrot rather than
5 the stick. This means that children are encouraged by
6 a system of rewards and incentives to improve their
7 behaviour from within themselves rather than have it
8 imposed from without.'

9 Then it goes on to the aims of the school which
10 include the eventual return in as short a time as
11 possible of the child to ordinary school, if
12 appropriate.

13 Do you have any reflections in relation to those
14 stated aims and functions?

15 MS LLOYD: They wouldn't be what we would have now, counsel.

16 And I don't think, from reading the information,
17 Ovenstone lived up to some of those inappropriate
18 expectations, I have to say, in the way that it's
19 worded, but it didn't feel to me that, you know, to
20 encourage the children to form effective and satisfying
21 relationships with adults and each other, when we look
22 at the evidence in front of us today.

23 MS INNES: I suppose again there's emphasis on improvement
24 of behaviour within the child themselves, which you've
25 already mentioned, as being the way in which these

1 issues were being approached.

2 If we can move on, please, to page 23, and if we
3 look down towards the bottom of the page, there's
4 reference to the Anderson and Lindsay report in 1997
5 which was with reference to the school -- the future
6 both of Ovenstone and Linwood, and I think that's
7 the report that you were referring to a moment ago in
8 your evidence, Maria; is that right?

9 MS LLOYD: Yes, that's correct.

10 MS INNES: They say there:

11 'We are struck during the study by the rather
12 uncertain feel of Linwood Hall. [Then it goes on]
13 Ovenstone staff appeared unhappy about the changes that
14 had taken place. In both cases, the residential element
15 seemed to have been allowed to wither as a result of
16 limited referrals and a lack of clarity about
17 objectives.'

18 Then it goes on to talk about the staff and then it
19 says:

20 '[There's] poor resourcing and staff morale being
21 palpably low.'

22 So there seemed to be, at this time, a move away,
23 I suppose, from children being there on a residential
24 basis which was then having a knock-on effect on staff
25 morale and what could be provided; is that your

1 understanding?

2 MS LLOYD: Yeah -- understanding is that it moved,
3 particularly in the '90s, towards more day pupils than
4 residential pupils and from the reading of some of the
5 questionnaires in 1997, I think staff were quite unhappy
6 at this and found it quite challenging between the needs
7 of a day pupil and the needs of a residential pupil.

8 MS INNES: In the document, you go on to collate some of the
9 figures in terms of the numbers of children accommodated
10 and I think if we can look, please, at the appendix
11 which is at page 102 of this document, we can see
12 numbers of children in the early '70s on that page, so
13 between 1970 and 1972.

14 Numbers seem to fluctuate. It looks as though
15 figures are collated on a regular basis, perhaps not
16 every week, but regularly, with up to about 14 or 15
17 children there during what might be called term time.

18 And then it does appear -- if we were to look down
19 at July 1971, for example, it appears some children were
20 there over what we would think of as the school holidays
21 as well.

22 MS LLOYD: It appears that way, in the information, yes.

23 MS INNES: And then if we go on to page 103, we can see some
24 other numbers that the council was able to collate from
25 different years, with 27 in 1963 and then 20 in 1989 and

1 then numbers around the 20 mark over the early 1990s,
2 but I'm not sure if those are children who were living
3 there on a residential basis or there during the day.

4 MS LLOYD: I'm unsure of that also.

5 MS INNES: If we can look back into the document again,
6 please, and if we can look, please, at page 46.

7 There's an undated document, which is information
8 for parents, which is quoted here and in the paragraph
9 that we can see on the screen, it talks about meetings
10 at which progress of a child is being reviewed and then
11 it talks about continual feedback is made to children
12 concerning their progress:

13 'The main way in which this is achieved is by the
14 daily awarding of points. These points are awarded at
15 what is called the community meeting which is
16 an assembly of all the children and all the staff.'

17 So do you have any comment on this points system
18 that seems to have been in operation at the time?

19 MS LLOYD: It seems a very old, dated and derogatory way of
20 working through progress. Progress for education should
21 be about how you're succeeding and progressing through
22 your learning. It appears, from the information
23 I've read, that this was mostly again about behaviour
24 and how the child or young person behaved and I am aware
25 that there was also withdrawal of points, et cetera, and

1 then sanctions also came about from these withdrawal of
2 points.

3 I'm also aware that it was very uncomfortable for
4 the children to be sitting with other children and staff
5 speaking about their progress -- or their behaviour,
6 I should say, in a derogatory way, including information
7 about things like wetting the bed or anything else.

8 So this is not an acceptable way to talk about
9 children and young people's progress and certainly not
10 in front of other children and staff. And I believe it
11 became a staff meeting about saying everything that was
12 wrong and what was happening that was wrong with the
13 children, rather than about progress of learning.

14 So it's a strange way to describe how you would --
15 or I, as an educationalist, would not progress in
16 children's learning.

17 MR ROSS: I suppose, again, just a reflection that we've
18 got, is that it reinforces some of the stuff that we've
19 said earlier which is around -- it's the role of the
20 adults to get the best out of the child. It's not for
21 the child to -- the child has no ability themselves to
22 make significant strides in the education without the
23 assistance of the adults, and again it just reinforces
24 that message and I think we have now certainly moved to
25 much more child-centred planning and trying to look at

1 the role of the adults or the network around the child
2 to get the best out of them to achieve their potential,
3 but these large institutions that have these big
4 meetings have the potential to -- I think for me, to
5 have the most damning effect which is to reinforce what
6 you're not capable of in a group of your peers.

7 MS INNES: Now, if we can move on to another document,
8 please. This is FIC.001.001.6365.

9 This is the response to parts C and D of the
10 Section 21 notice served by the Inquiry.

11 Within this, we see some quite extensive quotes from
12 logbooks that were recovered in relation to Ovenstone.

13 Perhaps if we can look, please, to page 3 and we see
14 that there's reference to a logbook, the Ovenstone Book
15 2, covering a period from 24 October 1970 to 6 May 1973.

16 There's notes signed by various people, including
17 Alexander Christie. Then it notes that there was a case
18 note on the file of a person who is known to the Inquiry
19 as 'Jordan' on his file, from 7 March 1973, that:

20 'During a social work visit to Ovenstone, the matron
21 advised that a member of staff was suspended from duty
22 whilst the allegations of child interference against six
23 children were being considered.'

24 And there's nothing else in the logbook about that.

25 And I don't think there was anything further in the

1 records of the person who is known to the Inquiry as
2 'Jordan'; is that right?

3 MS LLOYD: That's our understanding.

4 MS INNES: We'll come back to Alexander Christie in a bit
5 more detail in a moment.

6 Have you had an opportunity to look at this logbook
7 yourself or the summaries?

8 MS LLOYD: We've just been able to -- the information that's
9 provided to you, that's what we have also. We don't
10 have access to the actual logbooks, just the references
11 made in our A to D responses.

12 MS INNES: If we go on over the page, to page 4, it talks
13 about there being entries in relation to the children
14 and focus on the children's behaviour. There's
15 a paragraph beginning:

16 'The entries are more specific when they relate to
17 children displaying difficult and challenging behaviour.
18 The frequent sanction and punishment is sending children
19 to bed earlier or confining to bed.'

20 Do you have any comment in relation to that as
21 a sanction or punishment?

22 MR ROSS: Well, I suppose, I mean, I've -- kind of, over the
23 years gathered a view about just how harmful that is for
24 children and young people. So we've got children and
25 young people who are not in the care of their family and

1 in unfamiliar settings, often in large settings, being
2 cared for by strangers, often caring for them in a way
3 that perhaps their parents didn't, and sometimes the
4 care of their parents, we'd have to accept could have or
5 would have been better. And so I think for children to
6 be confined to their bed, to be isolated, to be often in
7 rooms that lack any warmth, I think, becomes a very
8 frightening place for children.

9 And we know that from what children tell us. Again,
10 it's just that lack of emotional warmth that comes from
11 staff to try to understand what is it that's driving the
12 behaviour and how can I support you to -- how can you
13 support me to understand it as the adult and how can
14 I give a caring response that's warm and nurturing.

15 And I suppose just the lack of record on Mr Christie
16 and then the detail of the children's behaviour I think
17 is an interesting thing, that staff are more focused on
18 what children are not doing rather than what the adults
19 in the environment need to be doing or we need to be
20 alert to.

21 LADY SMITH: It's also interesting in that the remedy as
22 seen is to exert control on the child and not to work
23 out what impact that will have on the child, even if you
24 continue, as the person in charge of the child,
25 thinking: what do I do to produce the outcome

1 I'm looking for? Which is that the child doesn't cause
2 me these difficulties, but nothing that gives us any
3 clue to why they thought, to take that example,
4 isolating a child in bed for lengthy periods was going
5 to produce the result they were looking for.

6 MR ROSS: I suppose, kind of, when you're reflecting on
7 practice over the years, there's also, at times, when
8 you look back, you know, in these institutions, where
9 it's all -- as children became an inconvenience to the
10 staff and therefore the way to address that difficult
11 behaviour was to confine them to their room, so that you
12 weren't burdened with what was difficult behaviour to
13 manage.

14 MS LLOYD: It seems like very much a control and sanction
15 approach to any sort of trauma from the staff and it
16 seems to be -- the logbooks, that I believe there's five
17 of, seem to be written by staff for, I feel, the
18 perpetuation of staff, because there's nothing regarding
19 who was on duty, who did what, what happened, and how
20 they're following it up. It was only about the
21 sanction. It wasn't, you know, 'Maria's misbehaved so
22 we're going to talk to her or do this with her', or --
23 you know, there seemed to be no resolution in place for
24 the children and young people to actually address it.

25 LADY SMITH: And not backed up by any psychological

1 knowledge or teaching to the effect, well, if you do do
2 this to the child, you're going to help the child.

3 MS LLOYD: Absolutely, and give them the chance to talk it
4 through, et cetera, which obviously isn't helped when
5 you do a community meeting with everybody the next day.

6 LADY SMITH: You might understand it if it was backed by the
7 science being to the effect that if you treat -- if you
8 do this with the child, it will help the child become
9 more settled. That wasn't there. Not that I'm aware
10 of.

11 MR ROSS: I think it's that lack of informed understanding
12 and I think that's, kind of, played out in where the
13 child's uncle visits and afterwards they're distressed
14 and their behaviour is difficult and they've soiled
15 themselves, but what that is is a loss of your uncle who
16 has come and left and the lack of informed understanding
17 by the staff has meant that that was a behaviour that
18 required punishment rather than a behaviour of
19 a distressed child who's seen a family member and on
20 them leaving, they're upset and distressed by that.

21 LADY SMITH: Thank you.

22 MS INNES: Thank you, James, that's the very entry that
23 I was going to refer to.

24 If we just scroll up slightly, we can see that there
25 was a child who displayed aggressive behaviour following

1 his uncle's visit:

2 'No supper as found soiled. He is bedded early as
3 a punishment.'

4 And then it's noted that he wets his bed
5 deliberately to have his own way, and that's noted by
6 Mr Christie, I think. So I think that's the incident
7 that you were referring to; is that correct?

8 MR ROSS: Yeah, that's correct.

9 MS INNES: If we go on to the next page, in about the middle
10 of the page, there is reference to the use of medication
11 as a way of managing challenging or difficult behaviour.
12 For example, the first entry says, referring to three
13 children: behaviour quite bad in the morning and Valium
14 was prescribed, tablets given essentially to good
15 effect, it says.

16 Do you have any reflection on the use of medication
17 to control behaviour in this -- in the way it's noted
18 here?

19 MS LLOYD: Completely inappropriate.

20 MR ROSS: I suppose you reflect and at times can't help,
21 but, you know, be horrified by the way in which young
22 people's distressed behaviour was -- managed and I
23 suppose for me, you know, again, when you reflect on all
24 of this, it's about when the behaviour of children
25 became too much for adults to manage, there was another

1 way that was sought to make that behaviour manageable
2 and medication being seen as that. I think we have to
3 reflect on, whilst we're not in a perfect system at this
4 point in time, we've made huge strides in terms of
5 trauma-informed understanding of the needs of young
6 people and we've got trauma-informed responses by our
7 staff, so that people -- behaviour's a communication
8 tool. So if you abscond, if you wet the bed, if you're
9 distressed, if you damage, there's something that the
10 young person is trying to communicate with us and
11 I think our staff are now much more skilled at trying to
12 understand what is the cause of the behaviour rather
13 than trying to consequence behaviour, because we know
14 the children have no control at times over their
15 emotional dysregulation.

16 MS LLOYD: To add to that, we also have much more regulation
17 round about the administration of medication. So in
18 this it seems that it was just up to one person to
19 administer. Obviously, we have now -- we need it to
20 come from GPs, et cetera, so it's much more highly
21 monitored, so that practice would be completely
22 unacceptable and illegal nowadays. But -- so I suppose
23 our policies are also -- in practice, are better in
24 terms of ensuring that that is done in a proper and
25 appropriate way.

1 MS INNES: Then, if we go on to page 6, first of all, at the
2 bottom of the page, there's a reference to the third
3 book, which covers 1974 to 1995 and, although it covers
4 that period, it provides, it says, a lot of evidence as
5 to how the school functioned between 1974 and 1987 and
6 then again from 1994 to 1995.

7 If we go on over the page, on page 7, it says that:
8 'There is evidence of a significant role in the
9 admission process and consultancy of the child guidance
10 team', so there seems to be involvement of psychologists
11 at this point in relation to children coming into
12 Ovenstone.

13 Is that more what -- a process that's more
14 recognisable today?

15 MR ROSS: Yeah, I mean, one, we have an expectation by the
16 Care Inspectorate; any admission to a -- children's
17 houses, there is a robust matching process and, for me,
18 the matching process, whilst we have clear templates and
19 a structure around that, the network of the child or the
20 information from the network would help us understand
21 their presenting challenges, the reason for that and
22 what might be the best response for the young person and
23 what we have to then look at is: has the staff team got
24 the capacity to meet the needs of this young person and
25 the children that they currently care for?

1 So matching is about not just the needs of that
2 individual child and young person, but what -- how that
3 house would function with the demands of the young
4 people that we found.

5 So I think that -- the guidance that we see in this
6 part of the A to D response is much more reflective of
7 the way in which we would do it now. I'm confident
8 we're much more robust and we're thorough in how we do
9 it even just with that. Because what you've got is
10 often people here who are not the closest to the
11 children making a decision about their needs and what we
12 do know is what they need in school is sometimes
13 different from what they need in care and again we have
14 to always be clear about how we separate that currently.
15 But certainly what we see there is, you know, a positive
16 step to doing something that's much more informed.

17 MS LLOYD: I think the missing step in this, and probably
18 from all of the evidence, is the missing voice of the
19 child in all of this to determine what is best for them,
20 and that's certainly progress that we've made in both
21 social work and education.

22 MS INNES: If we go on over the page, to page 8, we see
23 there's a paragraph beginning:

24 'In relation to discipline and managing challenging
25 behaviour, there are at least 12 records of using some

1 form of physical punishment between 1981 and 1983,
2 [which is] referred to as giving a child a slipper [and]
3 the severity of the punishment is measured by how many
4 slippers a child receives.'

5 So the records record the number of slippers a child
6 receives, but also, I think, in the first bullet point,
7 that they were able to choose between the slipper and
8 going to bed early, so that's recorded in the books.

9 It is said, in the bottom bullet point, that this
10 recording started [REDACTED] SNR [REDACTED] was [REDACTED]
11 and prior to that there had been no record of physical
12 punishment or restraint in the logbook. But for this
13 period, we see that there seems to be physical
14 punishment used in the form of a slipper.

15 Do you have any comment in relation to that?

16 MS LLOYD: It seems to be a form of corporal punishment,
17 that, as we know, and you know from the evidence that
18 was submitted, that Fife Regional Council submitted
19 a letter, I think it was for 1983 or so, to stop
20 corporal punishment being used in any education
21 settings. So it appears that this wasn't followed in,
22 terms of the logbooks that date from '83 onwards, and
23 that the slipper was still a form of corporal
24 punishment, as I believe that being sent to bed without
25 food, et cetera, is also.

1 So we did -- Fife Regional Council did instruct for
2 this to be phased out in education by '83/'84, but it
3 appears that this was still being used but now recorded.
4 MR ROSS: I suppose I think there's maybe more to add to
5 that because I suppose it's about the lack of recording
6 and what was that about. Was there a genuine desire not
7 to have the evidence the physical chastisement was
8 taking place, or had it become so commonplace within the
9 institution that no one's seen that as something that
10 was unacceptable and I think there's something about
11 that that is useful to consider.
12 I think also what that -- just again reminds me is
13 of the power that adults think that they hold and the
14 lack of accountability by adults who provide care at the
15 time, and I think certainly you see the logbook comes in
16 at the end, but there's something about the cultural
17 norm of an institution and the lack of recording I think
18 for me can sometimes signify two things, which is there
19 is an attempt not to be transparent and honest, or that
20 the practice of the time is so steeped in that form of
21 punishment that there's not seen as a need to record it
22 because it becomes common play.
23 MS LLOYD: Or there's too much to record.
24 MR ROSS: Yeah.
25 MS INNES: As you've mentioned, the issue of corporal

1 punishment, perhaps we could just look at those
2 documents just now, so the first one is FIC-000001379
3 and page 2 of that document is a memo, I think, dated 21
4 June 1983 which refers to the abolition of corporal
5 punishment in Fife schools and there's reference at
6 point 3:
7 'Corporal punishment would be phased out of Fife
8 schools during the course of the session 1983 to 1984,
9 the timing and arrangements for abolition to be remitted
10 to the Director of Education.'
11 And I think that's what you were referring to,
12 Maria; is that right?
13 MS LLOYD: That's correct.
14 LADY SMITH: So assuming that's a reference to the school
15 year, that would be phased out by end of June, beginning
16 of July 1984?
17 MS LLOYD: That's my understanding.
18 MS INNES: If we look at the bottom of the page, yes, it
19 says:
20 'It has been decided that a target date for
21 discontinuance of corporal punishment in Fife schools
22 will be the commencement of the school term in January
23 1984. Until then, corporal punishment may be used but
24 only by the headteacher or deputy headteacher. All
25 cases of corporal punishment must be recorded in detail

1 and available for inspection. Each and every case must
2 be reported in writing to me [this is from the Director
3 of Education] stating the reasons for it. Since there
4 is little to be gained by continuing to use the belt,
5 I would expect any cases to be reported to be few in
6 numbers and the circumstances quite exceptional.'

7 And then he goes on in the final paragraph to say:

8 'As a brief comment, it will be appreciated that
9 corporal punishment is not to be used in any
10 circumstances for handicapped pupils or infants.'

11 So I suppose there might be a question as to what
12 the definition of a handicapped child is.

13 MS LLOYD: I suppose the older definition of that would
14 be -- we would define now as anyone with an additional
15 support need.

16 LADY SMITH: And that would be of any type?

17 MS LLOYD: That would be how I would define -- well, how
18 I'm interpreting 'handicap'. You could say just
19 'disability', but now, as you know, disability is so
20 broad and, in education terms, we class it as anyone who
21 has an additional support need.

22 LADY SMITH: It's certainly not confined to physical
23 difficulties?

24 MS LLOYD: No.

25 LADY SMITH: Far from it.

1 MS LLOYD: They might be referring to that in that, I don't
2 know, because if you go back in time, that might be the
3 reference they're making to anyone who has got --
4 LADY SMITH: Although if we are talking about the 1980s, the
5 term 'mental handicap' might have been in common
6 parlance then. I think it probably was.
7 MS LLOYD: Probably, yes.
8 LADY SMITH: Ms Innes.
9 MS INNES: Yes. If we could go to SGV-001033774 and
10 page 10. At the bottom of the page here, this is
11 a document from Scottish -- which has been obtained from
12 the National Records of Scotland. It refers to
13 a memorandum from 1968, talking about, essentially,
14 a move towards an elimination of corporal punishment in
15 schools.
16 In the indented paragraph, it says there by
17 reference to principles:
18 'Corporal punishment should not be inflicted on
19 a pupil suffering from any kind of handicap; physical,
20 mental or (when it is manifestly persistent and serious)
21 emotional.'
22 So that would seem to accord with the broader
23 definition that you've given, Maria?
24 MS LLOYD: Yes, I agree.
25 MS INNES: And if we could look, please, at SGV-001033704,

1 and at page 2, this is a letter from the Social Work
2 Services Group to Directors of Social Work in -- on
3 22 August 1983, talking about corporal punishment, and
4 if we look down to point 3, it's talking about corporal
5 punishment in the context of education. It's then said:

6 'It is important, however, that we have reliable
7 information on the extent to which corporal punishment
8 of children is permitted in social work establishments
9 generally. I would be grateful therefore if you would
10 provide the same information as requested in relation to
11 all other social work establishments, including
12 residential and day care establishments.'

13 And if we go back to page 1, we see the response
14 from Fife Regional Council, dated 21 September 1983, and
15 it says, this is from the Director of Social Work, if we
16 scroll down slightly, and then back into the body of the
17 letter, it says:

18 'The position in Fife is that the use of corporal
19 punishment is not permitted within any social work
20 establishments which provide education on the premises
21 and this has been the case since the opening of
22 Melville House and Rimbleton House.'

23 So I think we know that Melville House opened

24 I think in the early 1970s.

25 MS LLOYD: Yes.

1 MS INNES: So -- sorry, late 1970s, 1977 it opened, so this
2 would seem to suggest that corporal punishment hasn't
3 been permitted or used since 1977 in Fife.

4 MR ROSS: I suppose that's the information in that letter,
5 there's a, kind of, strong message that the ethos is
6 that corporal punishment is not an acceptable way of
7 caring for children in the houses, and you're right,
8 this letter -- the opening of Melville House certainly
9 pre-dates this letter, so the letter would indicate that
10 from the opening of Melville House, there was the
11 intention that there was no punishment used in the
12 caring practices of the children and young people who
13 were placed there.

14 MS INNES: I suppose this is from the Director of Social
15 Work and we know that Ovenstone was managed by
16 education. Linwood Hall was managed by education,
17 I think, and Melville House was a slightly different
18 arrangement; is that right?

19 MR ROSS: Yes.

20 MS LLOYD: Yep. I think social work had the budget for
21 Melville House and education kind of ran it on
22 a day-to-day basis, is my understanding.

23 MS INNES: Because what is said in this letter doesn't seem
24 to accord with what we have seen from the material that
25 we have.

1 Now, if I can go back, please, to look at
2 FIC.001.001.6365 and to page 10. There's a paragraph
3 there beginning:

4 'The logbook is also full of entries relating to
5 staff issues, complaints raised by members of staff
6 against other staff members, including teachers,
7 houseparents and domestic staff. These entries conjure
8 a picture of a dysfunctional team with a number of
9 issues internally and also some external agencies such
10 as the child guidance team.'

11 And the first bullet point on 6 May 1982 notes that:
12 'The headteacher spoke to professional staff regarding
13 the discussion of Ovenstone internal matters with
14 outside parties. This constituted disloyalty to him, to
15 the staff and to the establishment.'

16 Do you have any reflection on these sorts of entries
17 and the culture in Ovenstone at the time?

18 MS LLOYD: It appears that it's quite hierarchical and that
19 there was obviously tensions between social work staff
20 and education staff by the way that it reads, and so was
21 quite an uncomfortable setting for staff members, which
22 means it was an uncomfortable setting for children and
23 young people also.

24 MR ROSS: I suppose, kind of, what I've taken from that was
25 just: where was the ability for whistleblowing? So if

1 all of the matters within the house should be contained
2 within the house or the establishment, then where's the
3 opportunity for scrutiny for challenging, for people to
4 understand what is the function of the house and, I
5 suppose, for me the headteacher's desire for things to
6 be contained internally, I think, in itself, can pose
7 significant risk to staff but also to the young people
8 that find themselves there.

9 MS INNES: If we look down to the bullet point, 14 May 1983,
10 it refers to a row between a teacher and a visiting
11 psychologist. The teacher left with his class, concerns
12 were raised that the psychologist assumes an air of
13 authority in relation to staff. And then 8 November
14 1984, there seemed to be issues about the child guidance
15 team not happy with the psychologist working at the
16 school.

17 So there appears to be quite a clash of different
18 people saying that they should or should not be working
19 there and what their roles were.

20 Does that give rise to a concern as to the safety
21 and wellbeing of the children who are there?

22 MS LLOYD: I think it goes back to what my colleague, James,
23 said earlier on, that if we don't understand from
24 a psychological point of view the trauma that these
25 children and young people are going through, then how do

1 we try to help them. So it seems a conflict in the way
2 in which things were being done or proposed, et cetera,
3 from the psychologist and obviously the team.

4 I don't know the details of that obviously, but
5 that's how it appears in my reflection of reading it.

6 LADY SMITH: There doesn't seem to be any respect for the
7 discipline and skill of the psychologist, particularly
8 if it's assumed that the child guidance team could do
9 just as good a job when they don't have that training
10 and understanding.

11 MR ROSS: I suppose what you see is a fracturing of
12 a professional network and I think what is, kind of,
13 interesting, when you, kind of, see the entries in the
14 logbooks, is that there's a lack of respect for
15 a different professional viewpoint and there's
16 an assumption that the care that's being provided is the
17 best that it can be and is not subject to challenge.

18 And again, so when you look at regulation, quality
19 assurance, being satisfied that the care is the best
20 that it can be and it's informed by something, then that
21 doesn't give you the sense that even the staff were in
22 a place to embrace a different opinion or any critique
23 of the care that's been delivered to the children in the
24 institution.

25 MS INNES: And if we move on to page 12 of the document, and

1 to a paragraph beginning: 'Overall' -- sort
2 of, reflections overall on the logbooks. It says that
3 they provide some evidence in relation to how the school
4 was run spanning a number of years. It says:
5 'While there is no evidence of proven instances of
6 abuse, there are a number of issues relating to
7 practice, for example, over-reliance on corporal
8 punishment such as administering a slipper.'
9 It then goes on:
10 'There is a set of complaints raised by children's
11 parents which appeared to be only superficially looked
12 at. There is no indication of interviews with the
13 children, apart from an instance when an allegation was
14 made against SNR [REDACTED].'
15 Again, do you have any reflection in relation to the
16 comment about the way in which complaints appeared to
17 have been dealt with?
18 MR ROSS: I suppose there's two things for me and one is
19 the, kind of, language where there's a proven instance
20 of abuse. We don't have to prove that abuse happened to
21 have believed that abuse was likely to have happened,
22 and I think that's -- that need that someone has to be
23 convicted for a child to then have been believed,
24 I think -- I think is something that we have to reflect
25 on and give a lot of consideration to the impact that

1 would have had on children and their families.

2 I think also the fact that there's no robust
3 investigation of every allegation and perhaps because
4 parents made the allegations on behalf of their children
5 or from their own observations, that those parents
6 weren't worthy of making an allegation against the care
7 staff that would have believed that, at times, these
8 parents hadn't done a good parenting job.

9 So the dismissal of any allegation and no robust
10 investigation meant that there was -- you know, from the
11 offset, there was no belief and -- that anything could
12 have happened to the children in their care.

13 MS LLOYD: And I think, just to add to that, you know,
14 that's probably the practice that's changed the most in
15 terms of within education and social work, we believe
16 the child or young person first and foremost and then
17 fully investigate anything that takes place. It
18 appears, on reflection, from what we're reading here, is
19 that complaints were made directly to SNR
20 who seemed to convince parents that, you know, anything
21 that had happened was quite acceptable.

22 And I think this also led to young people feeling
23 that why would they bother to disclose, because they
24 wouldn't be believed and that if their parents could be
25 convinced that something wasn't happening or that it was

1 just normal, then for them they probably gave up and
2 I think that came through some of the witness
3 statements, that they eventually just thought: why
4 should I bother? I'm not going to be believed and
5 nothing's going to happen anyway. So it's really
6 disappointing that this is in a logbook and it wasn't
7 fully investigated.

8 LADY SMITH: In fairness, I can see that there may be
9 problems, Maria, in proceeding on the basis that a child
10 is believed and that's that and if the child says X
11 happened, X must have happened. It might not have done.

12 The actual facts of an occurrence can often be more
13 complex than the child presents it. But are you really
14 saying that we needed to move to where we've got now,
15 which is, I think, proceeding on the basis, well, you
16 start from an assumption that what the child is telling
17 you is what's happened, and bearing in mind that's
18 through the child's eyes, and you certainly don't, as
19 you, James, rightly put it, say, 'Well, unless there's
20 been a conviction' -- and that's at a very high standard
21 beyond reasonable doubt -- 'we assume it didn't happen'.

22 MS LLOYD: Yes.

23 LADY SMITH: It's very much a question of your starting
24 point and supporting the child and taking forward what
25 they're saying to then look at what other factors there

1 are to take into account, what other evidence there is.

2 Have I got that right?

3 MS LLOYD: Yes, you have. Our starting point is believing,
4 because we encourage our children and young people to
5 come forward with any concerns and I think, you know, we
6 are at a standard now that we do that well to try to get
7 children and young people to come forward and to go to
8 a trusted adult and we emphasise that a lot in
9 education, in particular.

10 And we start with the belief in -- and we do find
11 that anything that is quite detailed, that they can give
12 us in detail, often tends to be true. You know, I think
13 we need to bear that in mind and in a lot of cases it
14 tends to be true in the detail in it. So we start with
15 that belief but obviously we then investigate and find
16 out the facts, but certainly we don't wait until someone
17 is convicted.

18 Within our settings, when we get something that we
19 feel is a credible allegation, we believe the child or
20 the young person and, in our practice, we suspend
21 immediately. That's to protect both the child and the
22 young person and the adult from any further accusations,
23 et cetera. So that's the process in which we use
24 immediately.

25 LADY SMITH: Thank you.

1 MS INNES: If we can move on to another document, please,
2 this is FIC-000001512; which is an updated Part B
3 response in relation to Ovenstone and, at 3.1, we note
4 that it is accepted that some children cared for at
5 Ovenstone were abused. Is that the council's now
6 position?

7 MR ROSS: Yes.

8 MS LLOYD: Yes.

9 MS INNES: And then you go on to list some allegations of
10 abuse and it says that it's accepted that they're likely
11 to be true.

12 The first person there is a person known to the
13 Inquiry as 'Jordan' and it's noted that this person
14 raised a claim in relation to sexual abuse. He had
15 alleged that he'd been sexually abused and that he gave
16 evidence at Cupar Sheriff Court and that Alexander
17 Christie was convicted.

18 Does the council now accept that Alexander Christie
19 was convicted in respect of the abuse of 'Jordan'?

20 MS LLOYD: Yes.

21 MS INNES: And if we move on over the page at the -- towards
22 the bottom of the page, there's reference to the risk
23 management team also looked into the case of a person
24 who is known to the Inquiry as 'Peter' and I think
25 there's reference to the civil claim and I think the

1 claim was initially repudiated.

2 He says in his statement to the Inquiry that he was
3 a person in respect of whom Alexander Christie was
4 convicted, that a nurse discovered Christie abusing him
5 and then things moved on from there.

6 Again, based on evidence shared by the Inquiry, does
7 the council now accept that 'Peter' was abused by
8 Alexander Christie?

9 MS LLOYD: Yes.

10 MS INNES: There's some other allegations noted on page 3.
11 There's an allegation also accepted by the council which
12 is likely to be true and this is a person who had made
13 an initial allegation of abuse against David Murphy, but
14 also indicated that he had been abused by other staff
15 members at Ovenstone.

16 From what's said in the Part B, the updated Part B,
17 it's understood that the council considers that his
18 allegations are likely to be true?

19 MS LLOYD: That's correct.

20 MS INNES: And then there's an allegation at the bottom of
21 page 3, which is against SNR [REDACTED] in October
22 1987, and there's reference to a parent having raised
23 that her child had been bruised and the child had said
24 that he was flung off the bed and he'd hit his face on
25 the bed head.

1 The evidence was insufficient for prosecution and
2 the social workers at the time found the child's
3 statement credible, and, I think, is that the basis upon
4 which the council accepts that this allegation is likely
5 to have been true?

6 MS LLOYD: Yes.

7 MS INNES: The material that is found in relation to the
8 view of the social workers at the time.

9 MS LLOYD: Yes, and also given the context of what we now
10 know occurred during the period of time at Ovenstone.

11 MS INNES: Then, if we go on over the page, to question 3.2,
12 there's reference to acknowledgement of systemic
13 failures and it is accepted by the council that, yes,
14 there were systemic failings; is that right?

15 MS LLOYD: Yes.

16 MS INNES: In terms of the systemic failings, in relation to
17 Ovenstone, are you able to identify what those failings
18 were or what some of those failings were?

19 MR ROSS: I think the key one for us is that there was
20 allegations of abuse that we know weren't investigated
21 fully and robustly to have come to an informed
22 conclusion and understanding of the care. So for us,
23 that's the, kind of, primary area of concern.

24 Second of all was the views of children weren't
25 accepted, listened to and heard, and those voices would

1 have been a rich source of information to inform us of
2 the care practices at the time, and the third aspect for
3 us is the lack of robust detailed recordings and, again,
4 that would have been reflective of the practice at the
5 time, but we have to acknowledge that the lack of
6 information has meant that we don't have the fullness of
7 information to bring the day-to-day, like, care of young
8 people to life.

9 I think the fourth one for us is around the lack of
10 respect and appreciation of the view of parents. We had
11 parents who raised concerns about the care of their
12 children, that they themselves weren't listened to and
13 heard. And the fact that children weren't able to speak
14 to the care staff and had to seek the views of their
15 parents meant that the conditions at the time weren't
16 supportive and secure enough for the children to make
17 disclosures to key staff that they felt could -- that
18 they could invest in and that there was a lack of what
19 we think was a safe relationship with staff that gave
20 the children the conditions to disclose.

21 MS LLOYD: If I could add to that, I think the lack of some
22 of the systemic failures are based on the problems
23 between social work and education and the relationships
24 there, which didn't allow for some of the practice to be
25 properly challenged and therefore investigated.

1 I think the lack of a complaints process, for
2 a formalised process for the children, that allowed them
3 to go outwith the home, which would have helped in terms
4 of having that other person to be believed. There
5 appears to be a lack of training for staff within the
6 residential home, Ovenstone as well, in terms of their
7 understanding of trauma-informed, ACE's, whatever way
8 you would like to say it, or just the basic
9 understanding that any behaviour is trying to tell us
10 something in terms of communication.

11 And I think also the lack of quality assurance.
12 I've noted the five logbooks. Who was looking at those?
13 Who was coming in to quality assure the detail of those?
14 What was being recorded? What wasn't being recorded in
15 terms of the Fife Regional Council to actually look and
16 see what was going on within the home? And actually, if
17 someone had read some of those logbooks at an early
18 date, they would have seen, I hope, the
19 inappropriateness of what was being recorded, how it was
20 being recorded, et cetera. So I think there's quite
21 a number of things that added to the systemic failure.

22 MR ROSS: I think what we kind of -- when we pull some form
23 of conclusion, I think what we accept is that the lack
24 of these measures, these mitigations to have provided
25 extra safeguards, has meant that for some of the young

1 people who were at -- cared for in this place that went
2 on to have life-long challenges and we know that being
3 in care in itself can create life-long difficulties, but
4 when you are subjected to forms of abuse in care, that
5 the impact of that for a lot of people never leaves
6 them. It has an impact on their mental health, it leads
7 into the route of addiction and offending and it severs
8 family relationships, particularly that of your siblings
9 and it distorts your view of your parents and your life
10 chances are curtailed, particularly with your own
11 children as you become an adult parent.

12 So I think we appreciate and accept that, you know,
13 the lack of rigour, as we've discussed, at the time has
14 meant that the opportunity to intervene and mitigate
15 wasn't there. As a consequence of that, people's lives
16 have been impacted forever.

17 LADY SMITH: Is there also another way or an additional way
18 that a council should regard this and, as you rightly
19 commented, the extent to which the impact of being in
20 care can damage somebody's life in so many ways, both in
21 terms of their health, their relationships with family,
22 family setups, which in turn means they grow into adults
23 who require continuing local authority services?

24 MR ROSS: Yes.

25 LADY SMITH: If you assist a child to become an independent,

1 well-functioning adult, the likelihood of them being
2 reliant on local authority services is much diminished,
3 isn't it?

4 MR ROSS: Yeah, and I think the kind of ethos, particularly
5 in the social work service now, is: these are the risks
6 that we think a young person is exposed to, either in
7 the community or by their family, and we might remove
8 those risks by placing them in care, but what risk does
9 the care system pose to these children and is that risk
10 greater and more detrimental than perhaps the risks we
11 are trying to manage currently, and I think that's
12 a change in practice and language but certainly I'm very
13 confident in Fife that that is a narrative in the
14 explanation that we require our social workers to
15 explore in their decision-making because sometimes the
16 consequence of care can be far reaching than the
17 consequences of the parental care or the risks that were
18 in the community.

19 I think that's how practice evolves and develops
20 over time, but we now have to look back at the body of
21 evidence we've got about the care system to understand
22 the risks associated with that and to use that now in
23 our current practice.

24 MS LLOYD: And just to add, I think we are using that
25 information and certainly James and I, reflecting on

1 this process, it's, I suppose, enhanced that and made us
2 even more committed to ensuring that care-experienced
3 children and young people are our target group to really
4 support. And I think James is understating the fact
5 that since he rejoined Fife, his philosophy of reducing
6 the amount of young people looked after in residential
7 or anywhere else, is a real commitment.

8 And obviously, within education, we want the kids to
9 come to our schools and not be pulled away. Because for
10 some of them, that's their success and their stability
11 in terms of their lives with their friendship groups,
12 because we all know that, come 16, those young people,
13 whether they're in care or not, will return to the area
14 they come from, to their families, because that's where
15 they want to be. So I think the change in approach,
16 because of the information that we now have, and
17 certainly from James's input, is not changing just
18 social works' attitude, it's certainly changing the
19 educational philosophy around care-experienced young
20 people, but we still have to do better with the outcomes
21 for care-experienced young people in education also.

22 LADY SMITH: Thank you very much.

23 MS INNES: Just finally on this document at page 5, there's
24 the question: 'Does the organisation accept that there
25 were failures in response to abuse?' And the answer to

1 that is: 'Yes'.

2 I think you've already given an explanation for
3 that, which is along the lines of complaints weren't
4 followed up. Children weren't heard. Parents weren't
5 heard. And other matters that you've already mentioned.

6 MS LLOYD: That's correct.

7 MS INNES: I'm going to move on to Linwood Hall and if we
8 just briefly look, please, at FIC-000001371, and the
9 very first page there, we can see a photograph of
10 Linwood Hall and I think on the second page, we can see
11 some further photographs of it and the grounds around
12 it.

13 From looking at the material that you've considered,
14 were there any particular issues arising from the local
15 authority because of the nature of the buildings that
16 were used by these different establishments?

17 MS LLOYD: I think, because this is the first time I've seen
18 a photograph, but having read some of the information,
19 it appeared that quite a lot of the buildings were older
20 and there was a number of buildings and big external
21 grounds, and there is -- my understanding is for
22 Linwood Hall in particular, there was a concern raised
23 through some of the inspections that the building was
24 deteriorating. So there were comments round about the
25 fabric of the building in terms of some of the

1 inspection reports, in terms of its appropriateness and
2 money to be spent in terms of the fabric of the
3 building, specifically for Linwood.

4 I don't know about the others in terms of their
5 appearance, sorry.

6 MR ROSS: I think it's very worthwhile adding that these
7 buildings are grand. They're huge. They're not homely.
8 How you manage children with dysregulated behaviour is
9 not being considered when opening these types of
10 facilities. How do we provide the emotional containment
11 for young people? That's very hard to achieve in large
12 buildings. The presence of staff becomes diluted for
13 young people when you're trying to span a large area.

14 So for me that, I think -- when we look at the
15 context of why we're here today, that allows the lack of
16 adult supervision of other adults when you're trying to
17 span huge environments.

18 But I think there's also another meaning around
19 we're giving often children from poverty something
20 better and I think we need to be clear about the message
21 that that conveys and how that, I think, prevents people
22 from challenging the system.

23 So we've almost taken children out of poor
24 communities and given them this and somehow we've done
25 something better. So I think there's lots of things

1 that we need to take from these pictures and these types
2 of buildings that were traditionally used to provide
3 care.

4 MS INNES: And if we could look, please, at
5 FIC.001.001.0003, and at page 3, so this is
6 Fife Council's response to the Section 21 notice in
7 relation to Linwood Hall.

8 If we scroll down to the bottom of page 3, we see
9 there reference to Linwood Hall School:

10 'Opened in 1974 and closed in 1998'.

11 It says that it opened because of a shortage of
12 places for children with social, emotional and
13 behavioural difficulties of school age.

14 Is that your understanding of what Linwood was --
15 what the purpose of Linwood was?

16 MS LLOYD: Yes.

17 MS INNES: It goes on to refer to Lendrick Muir School,
18 saying that, at the time, it was the only approved
19 residential secondary school in Scotland at the time.

20 So it was considered by the council that there was
21 a need for this type of provision; is that right?

22 MS LLOYD: Yes.

23 MS INNES: Then if we look down on page 4, towards the
24 bottom of the page, there's reference to the independent
25 review and the closure of Linwood Hall School in the

1 summer of 1998. Was that following the same review that
2 we've looked at in relation to Ovenstone?

3 MS LLOYD: Yes. The 1997 review, yes.

4 MS INNES: And again, was it for the same -- essentially the
5 same reasons, that there was a move towards the
6 mainstream?

7 MS LLOYD: Yes.

8 MS INNES: Now, if we could look, please, at page 29 of this
9 document. This gives us a sense of the numbers at
10 Linwood Hall and it tells us that at the time of the
11 Black & Williams Report, they were able to look back and
12 see that there had been residential accommodation for up
13 to 20 boys and 8 girls.

14 That seemed to be about the number of children who
15 were accommodated at Linwood; is that right?

16 MS LLOYD: Yes, that's the information I have also.

17 MS INNES: Perhaps if we might take the morning break, then
18 I'll move to the Black & Williams Report after the
19 break.

20 LADY SMITH: Okay. I think we've made good progress.

21 I mentioned earlier, we normally break at about
22 11.30, so if it's all right with you, we'll do that just
23 now and then move on to further evidence about Linwood
24 after that.

25 Thank you.

1 (11.28 am)

2 (A short break)

3 (11.45 am)

4 LADY SMITH: Maria, James, welcome back. I hope the break
5 helped and you're ready to go again. Is that all right?

6 MS LLOYD: Yes.

7 LADY SMITH: Thank you. Ms Innes.

8 MS INNES: Thank you, my Lady.

9 Now, the council's A to D response in relation to
10 Linwood Hall draws heavily on the Black & Williams
11 Report, which is at FIC-000000088 and we know that this
12 is an independent inquiry established by the Chief
13 Executive of the council following the conviction of
14 David Logan Murphy for the sexual abuse of children.

15 And we know that he had been at St Margaret's.
16 There had been complaints there and he'd been suspended,
17 and then, after a period, he moved to work at
18 Linwood Hall and that he was later convicted in respect
19 of sexual abuse.

20 If we can look in this document, first of all at
21 page 13, where it talks about 'The development of
22 knowledge about child abuse' and -- if we scroll down
23 a little -- so there is a paragraph beginning:

24 'At the same time as physical abuse is being
25 recognised, corporal punishment was still being used in

1 schools and in children's units. Some punishments given
2 at Secondary Institutions - to be Linwood Hall appear to have been
3 extreme. The pain recalled by some of the survivors
4 went beyond that expected of chastisement.'

5 So that seems to be what the authors of the report
6 found at the time when they spoke to people who had been
7 at Secondary Institutions - to be Linwood; is that your
8 understanding?

9 MS LLOYD: Yes.

10 MS INNES: Then it goes on:

11 'In relation to this presence of sexual abuse as
12 a phenomenon, while the existence of incest in families
13 was well established in those years and, indeed, long
14 before, the main focus of intervention was on the
15 punishment of the perpetrator. Little attention was
16 given to the effects on the victim. A senior manager in
17 social work recalls that in the 1970s there was
18 a reluctance in the police to accept allegations from
19 teenage girls and their mothers about sexual abuse by
20 their father.'

21 Then it continues in relation to how sexual abuse
22 was viewed as a generality.

23 Now, obviously at the time that allegations were
24 made against David Murphy, I think it was in the early
25 1970s, up to about 1973, we've just seen that Alexander

1 Christie was convicted for sexual abuse of children in
2 1973 in Fife.

3 I wonder if you have any reflections on how it was
4 or could be that allegations of other children at
5 another care home in relation to sexual abuse don't seem
6 to have been taken forward?

7 MR ROSS: I suppose when you, kind of, try to look back and
8 reflect is that we had care homes operated around the
9 same time, perhaps overseen by the same personnel, and
10 therefore the acceptance and the culture and the
11 practice would have been led by those people. So
12 I think that's one dimension that we had to give some
13 thought to.

14 But we know that abuse was happening in households
15 so -- and we knew that there was allegations of abuse
16 and therefore, irrespective of the evidence, based on
17 the research of sexual abuse at the time, abuse -- we
18 were being made aware of abuse and therefore we still
19 should have been able to take that on board and make --
20 and have some decisive action as a consequence of that.

21 But the three establishments that we're speaking
22 about today operated under the same personnel, albeit
23 different house managers. So we do need to give some
24 context to the culture and the belief that might have
25 been held by those senior management team at the time

1 based on the time in which they qualified and practised.

2 MS INNES: For example, I don't think the local authority
3 have been able to find any information about the
4 allegations about Alexander Christie and, indeed, his
5 conviction being reported in to any committee of the
6 council or to the council as a whole. I don't think you
7 found any evidence of that?

8 MS LLOYD: No, we haven't, and we've struggled to find any
9 personnel records to that specific person also, which
10 probably reflects the retention period of staff records
11 perhaps at that time. But, yes, we haven't been able to
12 find anything in relation to that, apart from what is
13 public.

14 MR ROSS: I suppose, also, we've, kind of, reflected it was
15 dependent on the view of the person at the time whether
16 or not a disclosure was going to be heard, listened to
17 and acted upon, whereas now what we know is we have, you
18 know, clear policies of practice, clear expectations of
19 the workforce, but there was people of positional power
20 who could make decisions as an individual about what
21 they were willing to act upon and record.

22 MS INNES: If we go on to page 15 of this document and to
23 the bottom of page 15, it refers there to Linwood Hall
24 was an educational resource offering day and residential
25 education provided by Fife County Council and

1 subsequently by the regional council:

2 'The care provision at Linwood Hall was the

3 responsibility of the Education Department and not the

4 Social Work Department.'

5 So that's quite clear in terms of the

6 responsibility, that here the Education Department had

7 responsibility for care and not just education?

8 MS LLOYD: Yes, obviously that's not the case now, but

9 I think the legal status back then allowed that to be

10 the case, but it's very unusual for me as

11 an educationalist to think that that aspect of

12 residential care was under the management and guidance

13 of education.

14 LADY SMITH: I suppose the problem was there was nowhere

15 else to put it at that time? Pre-Care Commission,

16 pre-Care Inspectorate --

17 MS LLOYD: Yeah -- yeah.

18 LADY SMITH: -- and otherwise the generality of Social Work

19 Department perhaps was seen as not being enough to

20 encompass it and, after all, education were looking at

21 these institutions so they could pick up what was going

22 on in care as well, couldn't they? So was the thinking.

23 MS LLOYD: Possibly. And I think probably because the main

24 function was supposed to be about education, it was

25 maybe perhaps perceived that that would sit better under

1 education than under social work.

2 MS INNES: Then it goes on in the sentence to say:

3 'The majority of young people at Linwood had active
4 links with their parents and returned home every second
5 weekend, unless they were being rewarded for some
6 achievement when they could earn an extra weekend at
7 Linwood.'

8 Do you have any comment on that reward?

9 MS LLOYD: It seems to be something that was made up by the
10 managers responsible to think it was a reward, but
11 I understand from the witness statements that it was
12 never given over to the victims that that was a reward.
13 Often they were told that their parents didn't want to
14 see them and it was left, as we know, under one specific
15 person, who has been convicted, to be the conduit
16 between families, parents and the children, and I think
17 the families, the parents, were also told that the
18 children didn't want to come home to see them. So
19 again, it seems to be a sanction and a punishment rather
20 than a reward for that and perhaps a way in which to
21 keep some of the children and young people there when we
22 look at where certain sexual abuse happened and when it
23 happened.

24 MR ROSS: I think we probably have to look at it slightly
25 differently as well in the fact that there's

1 a presumption that the state offers something better
2 than families, so why would Linwood Hall be a better
3 alternative to going to your family at the weekend?

4 I do think we need to be mindful of that, because
5 I think that infers around how even parents are treated
6 and how they can challenge the system. So the fact that
7 you could earn an extra weekend at Linwood Hall to
8 replace time with your family, I think, in itself, gives
9 an indication that there was a belief that Linwood Hall
10 was something better than family life, and I think that
11 then -- that class system and the way that we view the
12 people who live in poverty and the poor, I think, has
13 an impact on how you're able to challenge the system,
14 make allegations and how that would then be robustly
15 investigated, so ...

16 MS INNES: If we move on to page 19 at the bottom of the
17 page, we see the part of the report that deals
18 specifically with Linwood Hall, and it notes that the
19 authors of the report met with four survivors.

20 They note that this is a low response and they think
21 that was maybe linked to the fact that so few charges
22 relating to Mr Murphy's time at Linwood Hall were taken
23 into the final indictment. I think he pled guilty to
24 one charge in respect of somebody at Linwood Hall.

25 If we go on over the page, the authors say in the

1 second paragraph on this page:

2 'It was seen as the school that could cope with
3 those young people who could not be managed in
4 mainstream schooling. Evidently, senior staff were
5 proud that they could manage the most difficult pupils.
6 From correspondence in an administrative file located by
7 the present Education Service, the "good discipline"
8 that was achieved in the school seems to have been
9 valued by the then Education Department senior managers.
10 They felt that many of the pupils who had presented
11 considerable problems in other schools were being
12 successfully handled by Linwood Hall.'

13 And then it goes on that a few of the pupils
14 returned to their local schools.

15 Do you think that tells us anything about the
16 culture of Linwood?

17 MS LLOYD: I think it tells us something about the culture
18 of what senior managers perhaps believed to be the right
19 thing to do, because you were troublesome, seen to be
20 troublesome at another school, that we needed to put you
21 somewhere, so that you would behave.

22 And obviously the very strict corporal punishment,
23 et cetera, that appeared at Linwood -- or was carried
24 out at Linwood Hall would give the impression that the
25 young people were being managed successfully because

1 obviously nobody was finding out about anything else
2 that was going on. If they were in a mainstream school,
3 there would be exclusions, et cetera, you know, that
4 would take place so you would actually know that things
5 were going wrong within a school setting.

6 It also says that Linwood Hall had a self-perception
7 that they were doing a fantastic job, which reflects on
8 the reward to stay in at the weekend and not go back to
9 your family. So they obviously thought that they were
10 doing a really good job with these children and young
11 people.

12 MR ROSS: I suppose, in one respect, it's helpful to think
13 about the kind of ethos that's created by -- if managing
14 behaviour is the ultimate goal of the -- for the
15 determination of success by senior managers, at what
16 extent can staff do whatever they like in order to
17 ensure that those young people are managed.

18 And I think that's the thing that, when you just
19 reflect on all of the documentation, I think is also
20 worthy of just considering that -- so, you know, success
21 of a school setting is that behaviour is managed. That,
22 I think, opens the parameters of what can be used to
23 manage that behaviour.

24 MS INNES: If we go on to page 20, there's a paragraph
25 beginning:

1 'What is recalled, however, by the survivors is
2 a regime.'

3 So this is talking about corporal punishment was
4 being phased out over time.

5 'What is recalled, however, by the survivors is
6 a regime with harsh punishments which caused pain and
7 injury as well as humiliation for the recipient. The
8 language used by staff is recalled as very strong and
9 some allege that the head took pride in recounting his
10 forceful and dismissive approach to discipline during
11 his time in the Far East when serving in the Royal
12 Marines. Some of the survivors spoke about being got
13 out of bed by staff, being made to strip in the showers
14 and having their legs hit with wet bootlaces. This
15 wasn't linked to bed wetting.'

16 Then there's reference to a particular policy where
17 people would be hauled up -- sorry, a particular
18 punishment, where a boy would be hauled out of assembly
19 and deliberately shaken so that his head hit the wall,
20 and their memory is that that was SNR that
21 was meting that punishment out.

22 Do you have any comment in relation to that
23 material?

24 MR ROSS: Yeah, I suppose for me that is the emotional and
25 physical abuse as we would recognise it now. It's more

1 than harsh punishment. I suppose, just as I, kind of,
2 made some comment earlier around what is the regime that
3 creates good management of behaviour and, I suppose, for
4 me those practices make the situation for young people
5 very unpredictable and it's that level of planned
6 behaviour by staff that creates unpredictability in
7 a setting that almost means there is conformity because
8 if you can't predict what's coming next and the severity
9 of it, you do your best to try and manage. So what we
10 could see is that though that desire by senior
11 management to have an institution that is seen to manage
12 behaviour, what we haven't tried to do by senior
13 management is unpick what is it that's led to that good
14 behaviour in that setting as opposed to the mainstream.

15 So for me, we've created potentially the conditions
16 of a tolerance of adult behaviour that was -- even by
17 standards at the time, was totally unacceptable.

18 MS INNES: If we go on over the page, we see further
19 reference to Mr Murphy and there's reference to
20 a survivor remembering telling the headteacher as to
21 Mr Murphy's abuse:

22 'He remembers telling the headteacher about the
23 sexual abuse. He was openly disbelieved and told that
24 it simply didn't happen. Another survivor told the
25 headteacher in the presence of his mother. He was

1 called a liar by the headteacher, who was believed by
2 his mother, and made to go back. There is no evidence
3 that these allegations triggered any action by senior
4 staff.'

5 So I suppose that takes us back to issues that
6 you've already mentioned in your evidence, the way in
7 which an allegation is being dealt with by this
8 particular person in this institution, as opposed to
9 having a consistent approach.

10 MS LLOYD: It also refers back to, I suppose, a culture, the
11 fact that his mother just took the word of the
12 headteacher. It was back to that, you know, in, I have
13 to say in those days, that respect that the mother had
14 for authority perhaps and therefore believing what was
15 being said in a convincing way. It appears that,
16 obviously considering Linwood's reflection on them being
17 very good with discipline, et cetera, that that
18 particular person believed that that was the right way
19 to run that residential home and education by using this
20 sort of -- this was the norm. And I think that's what
21 James referred to earlier on in Ovenstone, it seemed to
22 be the norm of the way to behave and control behaviour
23 rather than actually look at the causes and the
24 communication from the children and young people.
25 MR ROSS: And I think, probably unknowingly by the

1 headteacher, is that by the disbelief of at least two
2 young people perhaps prevents any other young person
3 making further disclosures and therefore, you know,
4 empowers the person to continue to abuse and I think
5 what we know now is that the response that a disclosure
6 is met by is so important for the person's recovery from
7 abuse and again, perhaps at the time, that evidence base
8 wasn't there, but we know now that a young person who
9 makes a disclosure, how that is received by someone is
10 so important to assist them, both in the further
11 storytelling, but in how they recover from the abuse
12 that they've experienced.

13 So the lack of evidence, perhaps, at the time meant
14 there was a particular practice, but unfortunately the
15 conditions that were created by a belief that Mr Murphy
16 was honourable and a key member of staff has silenced
17 the young people in this house.

18 MS INNES: Just further down, we see a paragraph beginning:

19 'The survivors saw Mr Murphy as having a lot of
20 power in the organisation of care in the school.'

21 So is that what you referred to a moment ago in your
22 evidence, Maria, where you said that this person, who
23 was convicted, seemed to have a lot of control over the
24 care of the children in the home?

25 MS LLOYD: It appeared from -- again from the information

1 here in the witness statements, that he was there a lot
2 and he, you know, seemed to be on duty a lot, so -- and
3 he made lots of decisions and there was certainly
4 references to him contacting, as I said, being the
5 conduit between families and the young person. It
6 seemed to be that's the way in which the parents were
7 communicated with. So he was making lots of the
8 decisions with regard to the children. They weren't
9 being listened to. They weren't being asked. So
10 I think the fact that it appears he was on duty a lot
11 and had that specific role gave him a lot of power by
12 default, and that's what has come through to me.

13 MS INNES: I suppose the question that then arises from that
14 and also refers to the headteacher having a lot of
15 independent power, how do you guard against individuals
16 having too much power over the lives and education of
17 children?

18 MR ROSS: I suppose for me it's -- there's a whole range of
19 things that have to happen, but there has to be clearly
20 established policies and processes around how we would
21 expect all staff to go about their business,
22 particularly around allegations of abuse. It's not down
23 to the individual person to determine how we
24 investigate, that we're very clear in how all
25 disclosures would be met and I think there's something

1 really important that we now have established that's
2 also around that external scrutiny, and I suppose there
3 isn't -- at that point the headteacher is the person
4 that's in charge of everything, of every decision, is in
5 charge of care and education, particularly in an area
6 that they're probably less familiar with, but very
7 skilled in education. So external scrutiny is hugely
8 important and I've always, kind of, thought that it is
9 palpable in a children's house or residential
10 environment when things are not going right, you can
11 feel it. So that external person who is not steeped in
12 the culture and the practice is able to get a sense of
13 the environment, the practice, the demeanour of children
14 and the interactions of staff. So again, at that point
15 there was no external scrutiny.

16 I think also what we have is that ability to make
17 decisions for children as a collective network, so when
18 you have one person who is the decider of everything,
19 there's no challenge, there's no scrutiny, and there's
20 an interpretation by one person that becomes the
21 narrative. So again now we have that collective
22 decision-making forum and I think what we also now have
23 for children that wasn't there, is -- and again which
24 I think now prevents the likelihood of these things,
25 is -- are things like looked-after children's reviews,

1 the ability for a young person to call
2 a Children's Hearing and knowing that's there within
3 their gift to do so.

4 So I think legislative changes, regulatory changes
5 have enabled there to be less dominant people who can
6 control environments and the narrative that comes from
7 that and, kind of, my view has always been in any
8 children's care home or setting, the wind needs to blow
9 through.

10 So there needs to be the opportunity for external
11 scrutiny at all times and that there's robust support of
12 challenge or practice because cultures, I think we see
13 that in here, can become -- can develop without the
14 people who are practising in that way from knowing. So
15 how does someone else cast an eye on the culture and the
16 practice of an environment who's not part of it?

17 MS LLOYD: Within the school settings now, there's many
18 adults going in and out the schools to quality assure
19 the practice that's ongoing. So I think, in line with
20 what James is saying, now within education that
21 obviously are not residential settings, we have improved
22 child protection training for all staff.

23 We do it every August and then service day, where
24 every member of staff has to be child protection
25 trained. We have very good updated training. And

1 I think the fact that we now have, like, wellbeing
2 meetings, which doesn't necessarily include the
3 headteacher, it could do at a primary school, but
4 actually it's a collective group of professionals who
5 are respected to make decisions around the family and
6 the family are included in that decision-making process
7 and the voice of the child, whether they want to be at
8 the meeting or not is up to them, but is recorded and
9 valued.

10 So I think the whole approach is, kind of, stopping
11 this level of power by one person, because there's the
12 checks and balances in place because of improved,
13 I suppose legal requirements, but also improved policy
14 within Fife.

15 MS INNES: Now, if we look down to the bottom of this page,
16 we can see that the authors of the report recognise that
17 Linwood Hall had closed and that practice had changed
18 considerably in the intervening period and they didn't
19 make any formal recommendations in relation to what they
20 had recorded in relation to Linwood Hall.

21 We know, of course, that they made many
22 recommendations which have been looked at, I think,
23 before by the Inquiry.

24 Do you think that there are still things that you
25 can learn from what happened at Linwood? We'll come to

1 the specific issue of David Murphy moving from one place
2 to another in a moment.

3 But just in terms of what we've been looking at
4 here, is there anything that you would specifically take
5 away from this?

6 MR ROSS: I think for me -- whilst I think we've made huge
7 strides -- is the listening of the voice of the young
8 person and, at times, even young people who are in
9 a period of crisis, there's -- I'm not sure that we take
10 on board fully their views, their wishes, and I think
11 that's a lot -- you know, I think for staff there's
12 still a lot of work to be done in that area, albeit
13 we've made significant progress within that.

14 I think the other thing that we still have to think
15 about in how we deliver ongoing training is around how
16 we create the conditions for staff to be curious about
17 the practice of their colleagues without being
18 suspicious and I think that's something that I think is
19 hugely important and we still know the residential
20 settings culture is developed within staff teams and
21 I don't think we've made progress and have paid
22 particular attention to what is the training requirement
23 to do that type of work without it becoming a suspicious
24 working environment.

25 And I do genuinely think -- and I'm very confident

1 in Fife that we've made some progress in that -- is that
2 we're not the parent of children unless we have parental
3 rights secured through a permanence order and I think
4 there's still significant work needing to be done to
5 respect the views, the wishes and the voice of parents,
6 particularly of parents who make complaints.

7 And I don't think we're also there. I think parents
8 can be seen as being difficult and challenging and
9 because of their circumstances, we contextualize it to
10 that, where often they have a lot to say about the care
11 of their children and need to be afforded the right to
12 be heard, particularly when there's matters of concern.
13 And again, I don't think professionals across the system
14 often appreciate the voice and the rights of parents.
15 So for me there's those, kind of, three key areas that,
16 whilst we've made progress, there are still ongoing
17 significant progress we would want to take forward.

18 MS LLOYD: I also think there's something to add to that,
19 just in general in school settings, is that we tend to
20 hear, because I get a lot of complaints and it tends to
21 be from certain schools and certain areas.

22 I think we still have to look at the voice of
23 a range of social areas and backgrounds and, et cetera,
24 to make sure that the voice of all parents and all
25 children is heard, because I think some find it much

1 more challenging to come forward, particularly in
2 education and in residential, if your experience has not
3 been positive. And I think that's a cultural thing and
4 it's a society thing and I think we've got to work
5 harder at that and I think within education we have got
6 to work harder.

7 We did bring in -- social work did it first with
8 trauma-informed practice, we have brought in mandatory
9 training for all staff just under three years ago in
10 education and all staff in a school to be trained in
11 trauma-informed practice and de-escalation. And that's
12 been quite a feat because we decided in those two areas,
13 due to research and to hang our hats on it in a way,
14 with the idea being that in our 153 establishments or so
15 that we -- the same language is used and the same
16 approach is used. So that if you do move from one area
17 to another, you should -- a young person should
18 experience the same sort of language.

19 So I think some of this learning is probably
20 supporting some of the things we are doing, but we
21 certainly need to still keep looking at it and keep
22 bringing it up in conversation and certainly James and
23 I will have our own learning after this review to
24 actually look at anything else that we should be
25 focusing in on and I know the council will also.

1 MR ROSS: I think from some of the work that we are doing
2 actively is around how we challenge some of the societal
3 norms that are around, so residential houses still
4 continue to be dominated by teenage boys, and there's
5 still a view around behaviour that people think young
6 people are in control of, particularly with partners
7 and, you know, other local authority services. So, for
8 me, there's something about these young people are
9 vulnerable as a consequence of trauma and adversity and
10 they're the most vulnerable and at-risk group and how do
11 we always keep that at the forefront of our
12 understanding of behaviour in how we plan for them, and
13 not see anything that they say as being malicious, but
14 genuinely either a true and accurate version of the
15 events that have happened, or at times due to complex
16 trauma, it's an amalgamation of various past events that
17 have merged and we need to unpick that greater.

18 But I think these are things that we've made huge
19 strides on, but there's something that we know are
20 continued challenges and we need to continue to work to
21 do that with our workforce and particularly, as I think
22 Maria touched upon, a workforce is never going to be as
23 skilled and knowledgeable in all areas, because we have
24 a -- particularly in social work and social care,
25 a turnover of staff. So we need to make sure that our

1 staff have the right training and the knowledge at all
2 times to respond to the needs and complexities of young
3 people and never be in a position where allegations or
4 even at times some comments that are made by young
5 people are dismissed based on a perception of them.

6 MS LLOYD: I think the advent of social media means we
7 really have to be mindful of that, because social media
8 brings with it huge concerns. I think it's probably our
9 biggest concern now in education in terms of what is
10 being said and what's being done in the background, not
11 necessarily at school but outwith, and how that's
12 perceived or believed and how we act on that also.

13 And there's lots of misinformation and that can be
14 quite dangerous as well.

15 MS INNES: If we can move on, please, to page 28 and below
16 recommendation 3, there's a paragraph beginning:

17 'All the survivors we met had one question in
18 common: how could the same council allow Mr Murphy to
19 move back into a care setting after the allegations of
20 sexual abuse made in 1973? Especially as this had led
21 to his suspension and transfer to a post where he did
22 not have contact with young people?'

23 We've also heard that question from applicants who
24 have given evidence to the Inquiry. We can see that the
25 authors of the report considered the way in which he was

1 appointed. Obviously, there was an absence of
2 convictions at that time.

3 If we go on over the page, to page 29, it talks
4 about the application process in 1976. It would likely
5 be an interview with the headmaster and a manager from
6 education services.

7 And the homes adviser or the last manager of
8 Mr Murphy as residential worker had been asked -- they
9 couldn't remember having been asked for references, and
10 then it goes on to say:

11 'A former senior manager in Fife Regional Council
12 Education Services recalls speaking to interviewers
13 shortly after the appointment of Mr Murphy and advising
14 them to be cautious because of rumours about the aspects
15 of Mr Murphy's contact with young people.'

16 And then the report goes on from there.

17 And from reading this, what have you been able to
18 discern as to how it was that Mr Murphy was able to move
19 from one setting, where there'd been allegations and he
20 was suspended, to another care setting?

21 MR ROSS: I suppose the challenge that we have, less so now
22 but still we can hear it, is around innocent until
23 proven guilty. And at times, the HR response being one
24 of anxiety around the repercussions of the way in which
25 we use information where there's not a conviction and

1 I suppose, when we look at what we have now, is we have
2 really robust safer care and recruitment policies in all
3 aspects of care where there's greater independence to
4 the appointments panel, there's the requirement for
5 PVGs.

6 But we have to also be clear around that if you're
7 not convicted, that doesn't mean to say that it never
8 happened. We weren't able to prove that it didn't
9 happen and therefore all of that information has to be
10 used in informing decisions about safe appointment to
11 the young people that are there.

12 So I think the legislation and the governance around
13 recruitment is different now that allows us to be much
14 more robust in how we go about our business. I think,
15 sadly, when we reflect on the events at the time, there
16 was a particular view that was held of Mr Murphy that
17 went against the views that children held of him and
18 that enabled him to be a powerful person in the
19 organisation and to be able to be reintegrated back into
20 childcare settings.

21 None of that was safe. We know it wasn't safe by
22 the ongoing abuse, but also it wasn't legitimate to have
23 made that decision at that point in time and we have to
24 be deeply apologetic, at the very least, about the way
25 in which the management of him has led to children and

1 young people not being kept safe.

2 MS LLOYD: It seemed to be a culture thing again because
3 there is that element of social work informing education
4 that they had grave concerns, and if a colleague said
5 that to me, you know, it doesn't matter what policies or
6 procedures you've got in place, you would be listening
7 and acting on that. But I think James is right, our
8 procedures and policies are much more robust now, but
9 obviously they weren't in those days and there was
10 obviously conflict at a senior management level that
11 allowed people to, I suppose, a lack of respect to
12 actually someone saying that to you. You would know
13 that there was a real concern about this individual and
14 yet we allowed him to go into another residential home
15 for many years.

16 MS INNES: If we look down the page, there's a paragraph
17 beginning:

18 'It has been suggested to us that there may have
19 been a departmental status factor to take into account.
20 In 1976, social work departments were relatively new and
21 it may have been that the Education Department felt that
22 they had the experience to ensure that Mr Murphy was not
23 given the opportunity to abuse children. Once the
24 decision had been taken to employ him, they would not
25 have welcomed advice from those who they would see as

1 their juniors.'

2 So the authors say, 'We've not seen any evidence to
3 prove or disprove that', but they think it's
4 a possibility and I think that was what maybe you were
5 referring to in relation to the ongoing issues between
6 education and social work.

7 MS LLOYD: Yes.

8 MR ROSS: You know, I think it is still, I think, a really
9 important point for the Inquiry to think about the point
10 at which we make appointments. When information becomes
11 available beyond that appointment, at what point can we
12 do a U-turn and I think there is -- there are still
13 challenges across, you know, Scotland, around when you
14 make a conditional offer, that that somehow seems like
15 an unconditional offer from the offset and then further
16 information becomes known about someone, that
17 recruitment process can feel much more challenging about
18 withdrawing the offer.

19 And not in terms of things as serious as this, but
20 we do know that recruitment processes can become
21 challenging and that there's anxiety about the challenge
22 that comes from a person who does have the potential of
23 the author to be withdrawn.

24 So I think, whilst we have consummate safer
25 recruitment processes and a greater robustness, there is

1 something for me about how do we explore that going
2 forward and perhaps, you know, there's an opportunity by
3 the Inquiry and there is something about the weight of
4 information -- what's the weight being given to
5 information that's not been proven, particularly within
6 settings where there's vulnerable service user groups.

7 So you could have someone who has a catalogue of
8 allegation after allegation, never formally been
9 investigated and never perhaps been investigated by the
10 police or convicted, but there's a catalogue of
11 information that demonstrates a pattern and at what
12 point is that used to determine someone's suitability
13 for a post.

14 And I think that's the area that needs further
15 scrutiny and exploration.

16 MS LLOYD: I think -- just to back James up -- I think
17 there's a real challenge for us and there's a real
18 challenge in education to, once they're employed, to
19 sack. We immediately suspend when there's an allegation
20 to keep children and young people safe, so keep them
21 away, but actually going through to the end process is
22 quite painful, I'm going to use the word of, because of
23 the situation that it is, with regulations from GTC,
24 et cetera, and probably our own processes, the final
25 decision in our process in Fife for teachers is that the

1 final decision-maker is actually elected members.

2 So that leaves us open to that level of -- you could
3 say scrutiny or decision-making by people who are not in
4 the profession. I personally and professionally find
5 that very challenging. So I think what James is kind of
6 alluding to is that we can always be reflective in
7 looking back at our recruitment, our policies, but also
8 when allegations do come about and there's not
9 a conviction because, as you will know better than me,
10 convictions take a very long time. So in that time we
11 continue to suspend, et cetera, and not interfere with
12 the police investigation, but that's quite challenging
13 because our own fact-finding is limited then, but we do
14 go on the belief that, you know, if we have reasonable
15 belief, then that's the approach that we take, so we
16 don't always wait for a conviction, but just to reassure
17 the Inquiry, but we would still have the person
18 suspended until then.

19 LADY SMITH: And it's not just a question of proceedings in
20 the criminal courts taking a long time. The GTC
21 procedures, appropriately, proceed on the basis of
22 proper investigation and preparation and presentation,
23 and then there may be appeals.

24 MS LLOYD: I think, as you know and it's well publicised,
25 the GTC process is very slow and they tend to wait until

1 after we, as a local authority, have written a report
2 and put in the report, et cetera, and then it usually
3 takes quite a long time after that for the fitness to
4 teach.

5 They do put temporary restriction orders on some
6 staff which enables us to not move them from one school
7 to another, but, as I say, if it was a strong
8 allegation, they would be suspended anyway. But that
9 doesn't take away their registration immediately, it
10 just, kind of, postpones it.

11 So, you know, I think the regulatory bodies have
12 a role to play in this also and not waiting -- they
13 could carry out the investigation at the same time. It
14 does delay the process.

15 LADY SMITH: And if you look at it from the children's point
16 of view, particularly from the point of view of older
17 children who may be aware of these procedures taking
18 place, it's hard for them not to know exactly what's
19 happening as a result of them having spoken up.

20 MS LLOYD: Yeah. I think it's -- I think the only
21 reassuring thing is that the teacher wouldn't -- or
22 anybody in a school would not be in the school, so they
23 wouldn't have to see them again or be in contact with
24 them and that's the thing that I think we do do well in
25 Fife, we do do that. But you're right, in terms of some

1 of that dialogue with the young person, particularly
2 someone who's maybe, you know, a teenager, we probably
3 need to do better at reassurance and support.

4 I think schools do do a really good job via their
5 guidance teams and the named person, but we can always
6 do better in terms of that because there must be a fear
7 that that person is going to return or they're going to
8 bump into them and, et cetera, but we do reassure young
9 people that they are being believed and don't take that
10 lightly, but yes, there's always a concern.

11 LADY SMITH: Thank you. Ms Innes.

12 MS INNES: Thank you, my Lady.

13 If we can move on to page 30, in the second
14 paragraph there, it says:

15 'When the head who appointed Mr Murphy retired,
16 there was no mention made of any of the allegations,
17 either the ones in Linwood Hall or the previous ones, to
18 the succeeding head.'

19 So I assume that would be the allegations that were
20 made directly to the headteacher which he dismissed. It
21 then says:

22 'Following a period of review of procedures and
23 practice, the new principal made a number of changes,
24 including an embargo on solo working and the
25 introduction of a mixed gender care staff in the unit.

1 Mr Murphy asked for early retirement on health grounds
2 shortly after the appointment of the new head and left
3 within a year of the changes.'

4 So here it appears that the headteacher that has
5 been particularly influential in a complete change of
6 practice and procedure in the school, and I suppose that
7 would say something about the importance of the
8 leadership and how that sets culture.

9 Do you have any reflections on that?

10 MR ROSS: I think we kind of made reference to that in some
11 earlier evidence that we gave, that the culture
12 established by the leader is important and their
13 awareness and appreciation of that very awful things can
14 happen in their setting, and having that curious eye to
15 that is important.

16 But there's two things here, isn't there -- and
17 again we've given evidence around it, around the lack of
18 recording of information that is so important, because
19 organisational memory is not useful when you have
20 changes of staff, so that's been the issue here. But
21 equally, there's been a new ethos and culture that has
22 prevented potentially the opportunity to continue to
23 practise and perhaps has forced someone's hand to leave
24 their work.

25 But, again, it's how someone provides any

1 leadership -- any manager or leader with the scrutiny to
2 challenge and the support to ensure that the culture
3 that they do create is the one that we would all aspire
4 to. So -- because that's a positive change in the
5 culture, but equally there could have been a new leader
6 with a very different perception. So how do,
7 particularly for us in the local authority, ensure that
8 we have scrutiny, challenge, set a vision, set an ethos
9 and that we quality assure that that approach is
10 embedded and that we have evidence of that, and that we
11 hear from children that that's their experience of the
12 care that we hoped that they would receive from our
13 schools or our houses.

14 MS LLOYD: I think there's the challenge here about how we
15 record information, because information should have been
16 passed on, but obviously records back then, retention
17 records were different. We now have retention records
18 for 25 years for staff. Obviously, any disciplinary
19 stays in the record and is acted on for the year, but
20 the rest of the information does stay. So we would have
21 access to that nowadays, so that's probably a change in
22 our procedures and policy that would hopefully protect
23 from that -- prevent that from happening again.

24 MS INNES: Can I move to some other documents in relation to
25 an -- allegations that came out, I think, in the context

1 of the Black & Williams inquiry and they're allegations
2 against another staff member at Linwood Hall.

3 If we can look, please, at FIC-000001517 and this,
4 as you'll see, is an investigation interview with
5 a staff member who was then a workplace assessor in
6 November 2001, and there's reference to allegations
7 having been put to this person.

8 If we look down to the bottom of the page, in the
9 second last paragraph, it's noted that there was no
10 further investigation by the police, and then the worker
11 stated:

12 '... the context must be remembered. He was young,
13 started work before any training as a social worker.
14 When he completed his social work training, practices
15 within Linwood Hall started to change and would not
16 happen in this day and age.'

17 So this might tell us something about somebody with
18 no experience coming to work in Linwood Hall.

19 MS LLOYD: It seems to be an excuse given rather than
20 factual, because we obviously don't know what training
21 or experience anybody had in these environments, but we
22 did say earlier on that this -- the kind of systematic
23 failures, probably some of that does relate to
24 inadequate training and understanding. But I still
25 think people know the difference between right and

1 wrong.

2 MR ROSS: I suppose, kind of, the reflection that we've took
3 from it is you're trying to excuse the inexcusable and,
4 whether you're a qualified social worker or not, the
5 actions of the individual at that time we know were
6 ongoing over a period of time, were planned, there was
7 instruments that were created, so that's not something
8 about a lack of training. It's about perhaps a culture,
9 perhaps an accepted way of delivering care, but being
10 qualified or unqualified, I don't think, is something
11 that we can rely on as being the sole mitigation for the
12 practice.

13 MS INNES: If we go on over the page, we see a bit more
14 detail about the allegations. So they took place prior
15 to 1984 and the worker was employed from October 1974 to
16 July 1998 when Linwood Hall closed.

17 The first allegation, it says from the early 1980s,
18 is that:

19 '[This worker and] other members of staff would get
20 boys out of bed in the middle of the night. They would
21 be placed in two rows, look at the floor, not lift their
22 heads. [The worker] would rant and rave at them. If
23 they looked up, they would be taken to the shower,
24 possibly with pyjamas on or off.'

25 Then there's reference to being flicked with

1 bootlaces which we've already seen in the Black &
2 Williams Report.

3 Then the response to the allegation from the worker
4 in the second paragraph under his response, it says:

5 'The young people could be boisterous and difficult
6 to settle. If this happened, yes, they would remove
7 them from the room and stand them in the corridor. Yes,
8 they would be asked to face the wall.

9 'No, they did not insist on them facing downwards
10 and they would make them stand there until they settled
11 down and were ready to go to bed. If a young person
12 continued to be difficult, they would be removed to the
13 nearest place which was a toilet block.'

14 He then goes down at the end of the page to say that
15 in respect of what he did accept, he admits to
16 discussing this practice with SNR [REDACTED],
17 LUT [REDACTED].

18 'He didn't question it and did not advise as
19 improper. It was thought that this was a quick way to
20 get young people to settle. There was no malice
21 intended.'

22 So I suppose that might reflect on what you just
23 said, James, about this type of practice was being
24 condoned from the top?

25 MR ROSS: Yeah, and I think we have to reflect on some of

1 the comments we made earlier around if they stated an
2 aim and intention as to manage behaviour and that is
3 seen as the sign of success by leadership, then that, in
4 itself, opens the doors to particular practices by staff
5 being developed and evolving to take control of young
6 people.

7 So there is something about culture, something about
8 leadership, in that there was an acceptance by all that
9 that type of care could be delivered to young people
10 and, I suppose, when we've done our own reading and
11 reflections, when you start to label houses for troubled
12 and the troublesome, then that in itself creates the
13 conditions for particular caring practices to happen.
14 And we see that here.

15 MS INNES: Then over -- going on to page 4, sorry, we see
16 an allegation number 3 from 1982 to 1983, which is
17 a stick with a length of hose attached, which was called
18 'Winston'. It was used to threaten the young people if
19 they acted up in dorms during the night. It was alleged
20 that the staff member wandered about flailing this as
21 part of the bedtime regime:

22 'He admits that it was not one of his brighter
23 ideas. It all came about when a bit of wall bar and
24 a washing machine hose was discovered and joined
25 together to make a baton-type instrument.'

1 Then if we go down to the bottom of the page, he --
2 I think he essentially says on hindsight he realises
3 that this was wrong.

4 Then if we go on over the page, at the top of the
5 next page, he talks about not being proud of the
6 situation and he's asked how long the bar and hose had
7 been and he thought it was about 2 feet each and he
8 would wave the hose part about. He had no recollection
9 of hitting anyone with it, but it would be used as
10 a threat.

11 Do you have any comment in relation to that
12 particular issue?

13 MR ROSS: Again, the kind of reflection that we've got would
14 be that this is something that someone's been able to do
15 in the presence of a workforce, so there's nothing
16 secretive about this. There's something about it open.
17 It's the way in which -- it's a form of control, it's
18 a form of power that silences young people and brings
19 conformity but it's reflective of the culture and the
20 practice that was established by the leader and perhaps
21 accepted because there's reference to young people
22 speaking about this. When new people come to the house,
23 that they hear about it, so that communication, that
24 language will have been heard and shared with all the
25 adults. So there's something about the culture was

1 accepting of that.

2 And again, when we look at the conditions that
3 prevent young people being able to go against or
4 disclose things that are untoward, the ability to do
5 that isn't possible when you live in a place where such
6 a level of power is wielded by adults and that -- for
7 me, this instrument reinforces the level of power.

8 MS LLOYD: It also just reinforces the fear that these
9 children and young people must have felt because that
10 seems like a very long instrument that's wielded about
11 and was just appalling.

12 MS INNES: In about the middle of this page, there's
13 a paragraph beginning:

14 'Ian asked [the worker] if he could explain the
15 general practice within Linwood Hall at the time. It
16 had been alleged that there was a regime of fear and
17 intimidation.'

18 And then the worker stated that:

19 'LUT [REDACTED] was [REDACTED] who moved into
20 the teaching profession after the war, his specialist
21 subject was PE. His approach had a sense of military
22 discipline.

23 'He recalled a young person's pre-admission. LUT [REDACTED]
24 sat with the young person and social worker and parents
25 to explain the routine of the school. He would talk in

1 a low voice, then suddenly rap the table and then boom
2 out in a loud voice what the rules were. This was [REDACTED]
3 [REDACTED], fairly quiet with occasional explosions.
4 LUT [REDACTED] was 6 feet 2 inches tall, could be intimidating.
5 Now you can see that he was possibly not properly
6 equipped for the job.'

7 So I think that's the workers' reflection on
8 Mr LUT [REDACTED]. Again, I think that reflects what you've just
9 been saying about the type of regime that was there at
10 the time.

11 MR ROSS: I suppose also, I think, we reflect on these
12 residential school settings and the leadership of
13 education is that they -- potentially is that the focus
14 is on having compliance and achievement for an education
15 and not realising that actually providing good, stable,
16 attentive care would enable learning to take place and
17 as I think, when you look at the reason for establishing
18 these institutions, how they were led and managed
19 perhaps has established a way in which practice was
20 being able to come about and to be enforced.

21 And I think, again we've seen the -- in previous
22 evidence, when we've seen the kind of fractures in the
23 professional network, there's something about the
24 educational position at the time and perhaps culture and
25 ethos that would have been -- that compliance would get

1 good attainment or see educational results. And we know
2 that's not the case, but that again, I think, just feeds
3 what has sadly become the culture or practice by the
4 care staff.

5 MS INNES: If we go on to FIC-000001256, we see the outcome
6 of the disciplinary hearing following consideration of
7 these allegations, 21 January 2002.

8 If we look down to below the numbered paragraphs,
9 the author says that he's considered all of the
10 information presented. He says:

11 'I determined that there was a brutal uncaring
12 regime at Linwood which gave no thought to the
13 consequences upon the young people. Even by the
14 standards at that time, the practices were
15 unacceptable.'

16 And he says:

17 'I confirmed whether or not you were qualified at
18 the time. You had a personal responsibility for your
19 role in the practice.'

20 So I suppose that goes back to what you said, Maria,
21 about the lack of training.

22 MS LLOYD: And just knowing right and wrong and what feels
23 right and wrong for a young person.

24 MS INNES: Then if we go on over the page, we see that
25 obviously the allegation in respect of 'Winston' was

1 established, it was admitted, and then the practice in
2 respect of young people being made to stand in
3 corridors, the author says:

4 'I do not accept that this was defensible practice
5 but I do accept it was condoned by management.'

6 Then he also goes on:

7 'However, the practice of taking the worst offenders
8 to a position of secrecy, the toilet block, led to both
9 the young people and staff being in a vulnerable
10 position where abuse could occur.'

11 So the author seems to be recognising that quite
12 apart from the practice, the ultimate outcome of that
13 could put both staff and young people in a vulnerable
14 position.

15 Then he goes on to say:

16 'I considered your practice as gross misconduct
17 which could warrant dismissal.'

18 And ultimately, taking various things into account,
19 the person was issued with a final written warning.

20 And I think ultimately was moved from their position
21 as a workplace assessor to another role in the local
22 authority. Is that the outcome?

23 MR ROSS: Yes.

24 MS LLOYD: Yep.

25 MS INNES: Could I ask you please to look back at

1 FIC.001.001.0003 and page 67. So this is the Part A and
2 B in respect of Linwood and looking specifically at the
3 Part B.

4 So again the questions here are: does the council
5 accept that some children cared for at Linwood Hall were
6 abused? The answer to that is?

7 MS LLOYD: Yes.

8 MS INNES: And the basis of that assessment in terms of the
9 Part B is on -- primarily on Black & Williams Report?

10 MS LLOYD: I think primarily on that report and the
11 information that we gained from them and also David
12 Murphy's conviction.

13 MS INNES: Then over the page, at page 68, at 3.2:

14 'Does the local authority accept that its systems
15 failed to protect children cared for at the
16 establishment from abuse?'

17 MS LLOYD: Yes.

18 MS INNES: And I suppose one of the primary systemic
19 failings is the fact that Mr Murphy was able to work at
20 Linwood Hall?

21 MS LLOYD: Yes.

22 MS INNES: And then at question 3.3, on page 69, there's the
23 question about whether there were failures or
24 deficiencies in its response to abuse or allegations of
25 abuse. Again, what is the local authority's answer to

1 that?

2 MS LLOYD: Yes.

3 MS INNES: And again I think that's primarily based on what

4 we've discussed in relation to Mr Murphy?

5 MS LLOYD: Yes.

6 MS INNES: Now, I'm going to move on to Melville House.

7 If we can look, please, at FIC-000001182, which is

8 the local authority's response to parts A and B of the

9 Section 21 notice served by the Inquiry.

10 If we can look on, please, to page 5, under question

11 (vi) we see that Melville House School was opened by

12 Fife Regional Council in 1977 to provide residential and

13 educative care for boys aged 12 to 16 and it was closed

14 as a residential school in 1998.

15 So was it closed at the same time as the other

16 establishments we're looking at?

17 MS LLOYD: Yes.

18 MS INNES: For the same reasons?

19 MS LLOYD: Yes.

20 MS INNES: And, again, this is a focus particularly on boys.

21 I don't think there were any girls at Melville House; is

22 that right?

23 MR ROSS: Yes.

24 MS INNES: If we move on to page 23, in terms of what was

25 provided, there's reference to: 'The general purpose of

1 Melville House is to enable pupils to enrich their lives
2 by engaging in schoolwork and activities to assist them
3 to make sense of their society, cope with the demands
4 and pressures of their home environment and prepare them
5 to take an active part in society at large.'

6 Then it moves on to say that it was opened to
7 provide residential, education and care for boys between
8 12 and 16. It says:

9 'Experiencing severe, emotional and behavioural
10 difficulties, many of whom were placed under the care of
11 the authority by the children's hearing system.'

12 So that seemed to be the focus of Melville House.

13 Were you able to discern any sort of difference in
14 purpose between Melville House and Linwood Hall?

15 MS LLOYD: I think there's confusion between them and we do
16 see in some of it that some of the young people moved
17 between Linwood and Melville House as well. There's
18 some references to that.

19 I think the fact that it was just for secondary was
20 probably the significant difference between
21 Melville House and Linwood, but in terms of the other
22 things, it became a bit of -- aims were slightly
23 different, et cetera, but to be honest with you, it was
24 quite hard to differentiate the difference and the
25 different purpose, and I think that came out of the 1997

1 report also, that there was lack of clarity in the
2 purpose and objectives round about the different homes.

3 MS INNES: And this -- Melville House was jointly funded by
4 education and social work; is that right?

5 MS LLOYD: Yes.

6 MS INNES: Just staying on page 23, I think we can see, just
7 slightly further down, that when it opened it had 24
8 residential places and 12 day places.

9 Then it says:

10 'Originally day places were used as part of our
11 programme of returning home or integrating into
12 mainstream schooling and in later years, an increasing
13 number of boys went on a day basis than a residential
14 basis until ultimately it closed.'

15 MS LLOYD: Yes, that's correct.

16 MS INNES: If we look, please, at the bottom of page 25,
17 which talks about discipline of children: 'What was the
18 establishment's attitude to discipline of children?'

19 There's reference to an inspection report from 1992
20 which highlighted the following concerns and it notes
21 use of control and restraint, rough handling of boys,
22 practice of locking doors which led to a custodial feel
23 and then, at the top of the next page, it says:

24 'Former staff members have spoken about the regime
25 in Melville House. One former staff member working in

1 1981 indicated the following: punishment included
2 withdrawal of home visits [so this here is the
3 withdrawal of a visit as opposed to maybe it being
4 described as a reward]; the withdrawal of pocket money,
5 public disapproval of their actions at Melville House;
6 public accountability meetings [and] physical
7 punishment.'

8 That seems to have been back round about the early
9 1980s; is that correct?

10 MS LLOYD: Yes.

11 MS INNES: Then if we look down to the next question, which
12 is:

13 'Were there changes over time in terms of the
14 establishment's attitude to discipline of children?'

15 And it says:

16 'There was a greater level of scrutiny within
17 Melville House following allegations of abuse. Regular
18 announced and unannounced inspection visits took place
19 from 1991 paying attention to discipline used in the
20 house. Despite this increased oversight, there remained
21 reports of inappropriate use of discipline. It is
22 therefore unclear whether there was a change of attitude
23 embedded within the house.'

24 So ...

25 MS LLOYD: There seems to have been quite a number of

1 inspection visits. I think they were almost yearly from
2 1992 onwards. 1993, I think, noted that there were only
3 14 of the 30 recommendations from the previous year
4 actually progressing, not actioned, just progressing.

5 And there was more information and further
6 unannounced inspections, where the mention of restraint
7 was yet again brought up and there was further
8 information, inspection snapshots in 1994, a further
9 1995 unannounced inspection, which restraint was
10 mentioned again. So from the information that we've
11 been reading, it doesn't appear that there was much
12 change in terms of practice.

13 MR ROSS: I suppose though I think it's useful to reflect on
14 that, because the idea of annual inspection, planned or
15 unplanned, become normative and I suppose it's about
16 what was the purpose and function of inspection and at
17 what time were the inspectors willing to take decisive
18 action and for me, I think there's some reflections on
19 that and we see that has been something up until fairly
20 recently where continuously providers of residential
21 care, inspectors see them falling short, but there are
22 recommendations or requirements without any clear
23 timescale or evidence of change being made and I do
24 think that's been something that we've seen change more
25 latterly with the Care Inspectorate bringing enforcement

1 measures into children's provision.

2 But for a long time where there's been a concern,
3 there's been practices, there's not been the use of the
4 inspection regime to really challenge and bring about
5 change and to really enforce, I think, a different
6 expectation of the provider.

7 And, as I say, for me in the last two or three years
8 we've seen certainly the Care Inspectorate using their
9 powers much more, but that's a fairly recent change, I
10 would say, from my kind of practice experience. So
11 therefore when inspections that say the same thing and
12 find the same thing but don't expect to see a change or
13 demand a change, then what an inspection means to staff
14 becomes less over time. So therefore this inspection
15 regime has been complicit in, I think, allowing
16 a practice to continue by not -- by forcibly expecting
17 something different to happen.

18 MS LLOYD: It questions what information went back to senior
19 managers and what action we then took in Fife, because
20 it isn't the job of the Inspectorate to change the
21 practice. That's the job of the employer.

22 MS INNES: So if we look at a couple of those inspection
23 reports, so FIC-000001452, is a report from 1991. If we
24 go to the first page.

25 This is 18 to 22 November 1991. If we can look at

1 a couple of issues here, page 24.

2 If we scroll down to (c):

3 'Teachers report meeting. School community meeting
4 held in the afternoon after school.

5 'This is a large meeting where education staff and
6 social work staff meet with the youngsters to report on
7 the boys' behaviour at school. Other staff can also
8 comment on the boys' behaviour. The meeting is chaired
9 by the principal or the vice principal. Rewards for
10 achievement are also acknowledged or distributed.'

11 And then:

12 'Four meetings were observed by inspection
13 officers.'

14 And there were some positives.

15 If we go down to point 3, it says:

16 'It was noted that the boys did not respond well to
17 having their disruptive behaviour criticised in public
18 and their reaction tended to lead to them being
19 reprimanded again or required them to leave the room.'

20 So that's the response of the boys to this public
21 meeting and do you have any comment on this particular
22 process?

23 MR ROSS: You know, I think in all of this, I think just
24 the -- I think the impact of emotional harm is greater
25 than, I think, people appreciated then and it has a toll

1 on people that, I think, impacts on them life long.

2 Again, I mean, you'd reflect on some of these
3 practices, that, you know, I'm more inclined to believe
4 that's about keeping young people in their place and
5 I think being clear about who has the position of power
6 and that way of when you start to belittle people, then
7 their value of -- their self-value becomes less and
8 I think that gives people much more power over them.

9 LADY SMITH: And if at this meeting, as is recorded,
10 achievements were also being publicly marked, it would
11 really rub the salt into the wound of the boy who was
12 having his misdemeanours made public.

13 MR ROSS: It's just a greater way of reinforcing someone's
14 inadequacies that would have been viewed at the same, so
15 to -- and I think it becomes very unhelpful in
16 environments, where you have dysregulated young people,
17 to pitch young people against each other. That also
18 creates a position of power between young people and
19 allows for -- and we know that abuse can happen between
20 young people in care settings.

21 So I think you've got to be careful about the
22 conditions that we create through practice that enable
23 different groups of people to take on power.

24 MS LLOYD: And also the effect on the young people's
25 self-esteem, given what was being said and discussed and

1 again it comes back to the disclosure. It's unlikely to
2 warrant any young person disclosing anything to those
3 people who are also chastising them and belittling them.

4 MR ROSS: It also -- I think -- just the inspection report
5 finds practices that go against the ethos of the
6 establishments. So, in other words, if you, sort of,
7 looked at the kind of vision and the values of
8 Melville House and unfortunately some of the practices
9 that are now being reported by inspectors are
10 contradictory of what the house was set up to achieve.

11 MS INNES: If we look at page 26, we see an example in the
12 middle of the page, point 1:

13 'A member of staff raised the issue of a boy
14 refusing to attend to his personal hygiene. The
15 inspection officers were of the opinion that this was
16 an inappropriate setting [so this was at one of these
17 meetings] to discuss such a sensitive matter and later
18 brought this to the principal's attention. The
19 principal agreed that this had been inappropriate.'

20 And then if we move on to page 54, we see some
21 essential recommendations that the inspectors make.
22 Point number 1:

23 'Staff shouldn't use sarcasm as a means of
24 controlling behaviour.'

25 At number 2, there needed to be ongoing discussion

1 and training on restraint. At number 3, the practice of
2 holding large meetings to report on behaviour,
3 particularly negative behaviour, had to be reviewed.
4 And then at 5, there's reference again to consider not
5 using the morning assembly meeting to discuss the boys'
6 behaviour, which could be addressed in another forum.

7 So the inspectors appeared to have identified
8 certain things as essential, but I think you said in
9 your evidence, Maria, that these were not implemented as
10 we can see in subsequent reports.

11 MS LLOYD: Yeah. And it's a different aspect now because
12 anything, as James was referring to, with the
13 Care Inspectorate or inspection of schools, senior
14 managers would have that information and that report and
15 we'd have it immediately because we're there throughout
16 the process and for the feedback and, therefore, we
17 would be putting an action plan together and supporting
18 the establishment or school in order to address all of
19 these numerous recommendations.

20 So it would be on us to do that to ensure that
21 a kind of return visit, that all of these things had
22 been actioned and achieved, but obviously, dating back
23 on the information we have on this, that wasn't the
24 process back then.

25 MR ROSS: I suppose I always think it's important to think

1 about inspectors shouldn't tell you something that you
2 don't know already. So what was it about the culture
3 and practice of Melville House that required inspectors
4 to shine a light on that, rather than the principal or
5 the leadership team knowing that that was the practice
6 and doing something prior to inspection to address it.

7 So I think -- and I think that when we look at the
8 fact that then future inspections picked up on the same
9 themes that the leadership team acknowledged, but did
10 nothing about, probably takes us back to that principal
11 point, which was there's a culture in the leadership
12 team and a practice that was accepted and known about
13 and perhaps actually supported and whilst inspections
14 came in and gave -- you know, didn't support that
15 particular way of providing care, clearly the leadership
16 team genuinely believed that that was, because there was
17 nothing done over many, many inspections to address it.

18 And I think that's unfortunately created the
19 conditions for what we've seen in Melville House, which
20 is years of allegations taking place by young people and
21 I think the culture and the environment has created the
22 conditions for that to happen.

23 MS INNES: Thank you very much. The lunch break now,
24 perhaps?

25 LADY SMITH: We'll take a break just now for lunchtime and

1 then resume at 2 o'clock, if that's all right with you?

2 Thank you.

3 (1.00 pm)

4 (The luncheon adjournment)

5 (2.00 pm)

6 LADY SMITH: Maria, James, welcome back. I hope that's been

7 helpful to have the lunch break and you're all fresh and

8 energised and ready to go again; is that all right?

9 MS LLOYD: Yes.

10 MR ROSS: Yes.

11 LADY SMITH: Thank you. Ms Innes.

12 MS INNES: Thank you, my Lady.

13 If we can look at FIC-000001182, and page 66, and if

14 we go down to the bottom of the page, we'll see the

15 Part B response. So, this is the local authority's

16 response to Part B of the notice in relation to

17 Melville House.

18 The first question there is again:

19 'Does the local authority accept that some children

20 cared for at Melville House were abused?'

21 The answer to that is?

22 MS LLOYD: Yes.

23 MS INNES: Then, going on into the assessment of the extent

24 and the scale of the abuse, this is based on a number of

25 points that are made, so there's reference to the

1 Director of Social Work indicating that there were 51
2 incidents of abuse involving 34 boys since
3 Melville House's opening. And I think that's from
4 material that the Director of Social Work collated at
5 the time in relation to allegations; is that right?
6 MS LLOYD: That's my understanding, yes.
7 MS INNES: Then it says that concerns of abuse continued
8 after that, resulting in several inquiries. So some
9 matters were referred to Sheriff Kearney in 1991, and
10 was that in the context of his investigation into
11 childcare practices in Fife; do you know?
12 MS LLOYD: The information I have said that it was with
13 regard to staff member statements that had been raised
14 with -- regarding aggression, a culture, at
15 Melville House.
16 MS INNES: So these statements were perhaps made around at
17 the time of his investigation perhaps?
18 MS LLOYD: Yes, I think it was 1989.
19 MS INNES: And then there's reference to a solicitor who,
20 I think, was a maybe local authority solicitor, Ian
21 Mathieson, conducting an investigation, which determined
22 that no formal action would be taken. However, he
23 questioned the way in which complaints were dealt with
24 when they arose in Melville House.
25 That seems to be another investigation; is that

1 right?

2 MS LLOYD: I don't know if it's a separate one or the same

3 one. I'm not clear on that, sorry.

4 MS INNES: Then it refers to there being an independent

5 inquiry to see if there were further actions to be

6 taken, and if we go on over the page, there's

7 a reference to the type of allegations of abuse, so

8 physical assaults, excessive use of force within

9 restraints, staff reports indicating violence was used

10 to show supremacy among the staff team, inappropriate

11 use of sanctions, locking children in their room and

12 having clothing forcibly removed.

13 I think that's, perhaps, a summary of a number of

14 different allegations that the council have accessed in

15 their paper files; is that right?

16 MS LLOYD: Yes.

17 MS INNES: And then it says:

18 'These matters were investigated by the Education

19 Department when they arose with no further action being

20 taken.'

21 But there's been a question about the independence

22 of the complaints process within Melville House with

23 social work staff frequently challenging the outcomes of

24 investigations.

25 So this, I think, probably takes us to one of the

1 particular issues with Melville House, that there was
2 a clear clash between social work and education; is that
3 your understanding?

4 MS LLOYD: Yes.

5 MS INNES: Now, if we look at some of the material in
6 relation to this at FIC-000001444, and at page 76, this
7 is a letter from the Education Department to the
8 Director of Social Work, dated 26 January 1987, and it
9 refers to a particular child and it says:

10 'I refer to your memo of 11 December 1986 and the
11 complaint made by [this child] against a [staff member]
12 which I have investigated and found not to be
13 substantiated.'

14 If we scroll down, I think we see that this is from
15 the Senior Assistant Director of Education, so he's
16 investigated the incident and it's not been
17 substantiated and he says:

18 'Given the long delay between the date of the
19 alleged incident and the reporting of it, and also the
20 fact that [the child] met with his social worker in
21 October 1986 on two occasions and the fact that there
22 was a childcare review in November 1986 at which no
23 mention was made of the allegations, it would have been
24 better for your staff to have discussed the allegations
25 with the staff at Melville before instigating formal

1 procedures. If there is not going to be some practical
2 time guillotine on the raising of formal complaints,
3 given that previous opportunities were presented, we
4 could run into very great practical difficulties. It
5 may be that this aspect could be considered in any
6 review of procedures.'

7 So I think there's probably a few things in there
8 that you might wish to comment on. So, for example,
9 there is a suggestion that there had been opportunities
10 for the child to make the allegation and he hadn't made
11 the allegation and there's a suggestion that there needs
12 to be a timeframe within which allegations are made and
13 considered.

14 Do you have any comment on that?

15 MR ROSS: I think I suppose the difficulties that we've got
16 is that we know from some of the other evidence that
17 we've heard is that social workers weren't often made
18 aware of allegations that children had made. It was
19 held by the staff in the houses, so you wouldn't -- you
20 can't assume that the social worker would have known and
21 I think we just have to be mindful of that.

22 I think the lack of clarity around whose role it is
23 to undertake an investigation, I think, is also not
24 helpful in this and that's probably led to something
25 being unresolved, but there is no timeframe around

1 investigations.

2 So children can make allegations at any point about
3 current or past abuse and all of that has a merit to be
4 investigated and I think to put some kind of embargo of
5 time on things like that is an unhelpful suggestion.

6 But I think what -- the last sentence, I think, is
7 helpful because it perhaps indicates that either the
8 review -- the procedures that were currently in place
9 were absolutely not fit for purpose or perhaps there
10 wasn't procedures in place at all. So that's led to all
11 of these things coming to some fruition. But I think
12 just, again, it's when there's fractures in professional
13 networks, the voice of the child gets lost in all of
14 that and there's no ownership of it by education despite
15 at that point, you know, having the role of leading the
16 organisation.

17 MS LLOYD: It also appears, from reading it, that education
18 investigated themselves perhaps and, you know, that's
19 not the best practice for such a serious allegation.

20 MS INNES: And it also comments that the social workers
21 should have discussed the allegations with the staff at
22 Melville before instigating formal procedures, which
23 I suppose goes back to you need to have a proper
24 procedure in place, so that everybody knows how it runs?

25 MS LLOYD: Yep. And we also would never advise someone to

1 go to the possible abuser to raise an allegation,
2 because that would put the child in an even more
3 vulnerable position.

4 MS INNES: If we can look at another document, just again as
5 an illustration of issues between education and social
6 work at the time, it's FIC-00000001344 and page 33, and
7 here we have a memo to the Chief Executive of the
8 council, from the Director of Education on 24 April
9 1990. The subject is allegations of assault at
10 Melville House.

11 And he says:

12 'I refer to your memo of 13 April addressed to the
13 Director of Social Work. In light of your conversation
14 with Mr MacGregor, [who we know is the Assistant
15 Director of Education] I am assuming that you have
16 received further reports and allegations of assault
17 emanating from the Social Work Department. I note in
18 this regard that it is your intention to arrange
19 a meeting with the Director of Social Work, Director of
20 Corporate Services and Director of Education.

21 'Clearly, if there are allegations and they are such
22 as to warrant investigation, then we will most certainly
23 carry these out in a thorough and accountable manner.
24 However, it does seem as though in the majority of cases
25 the allegations are being elicited from former pupils of

1 Melville House; none of these allegations seems to
2 emanate at the time and all tend to be retrospective.
3 The most recent case investigated by Mr MacGregor, which
4 is clearly unsubstantiated and of no substance
5 whatsoever, came from the Acting Client Officer in the
6 Social Work Department talking to a person in Glenochil.
7 The staff at Melville House are now beginning to be
8 concerned about these matters and one of the teacher
9 professional associations has already written to me
10 wishing me to have a meeting to explore the extent to
11 which the staff of Melville House should continue to be
12 subjected to stress and worry, especially in the light
13 of the statement made by the Chairman of the Education
14 Committee and the Chairman of Social Work Committee on
15 behalf of the council.'

16 There is then reference to the local MP writing
17 reports in the newspapers and then the final paragraph
18 says:

19 'The extent to which Melville House is being
20 attacked on a continuing basis by the Social Work
21 Department is a matter of concern in terms of the
22 provision of a balanced range of provision to meet the
23 needs of youngsters' social, emotional and behavioural
24 difficulties.'

25 So here this is a bit later than the letter that we

1 looked at, but there are questions raised about,
2 essentially, a suggestion that social work are actively
3 eliciting allegations.

4 Do you have any comment in relation to that?

5 MR ROSS: I suppose that, fundamentally, it is the role of
6 the social worker to assess risk and manage that risk
7 and share that with professionals and services. So
8 there's a lack of understanding or appreciation of their
9 role.

10 And I think it's also right to just comment on that
11 it's the person who made the disclosure when they were
12 in Glenochil, it's not uncommon for someone to make
13 a disclosure when they're no longer living in the
14 environment that was of risk. So that doesn't make it
15 less valid and, again, it's an appreciation of some of
16 that knowledge that would be helpful.

17 But I think we've heard it from a number of
18 documents where social workers have been concerned about
19 the care and the treatment of young people in
20 Melville House and have tried to escalate that for
21 further investigation and have felt that that's not been
22 thoroughly investigated, but they're right within their
23 remit to continue to raise that at any opportunity.

24 So I think that's -- for me, I think the social work
25 practice at that point is one that you would -- that is

1 positive and clearly tried to be a safeguard to the
2 young people, albeit perhaps it's not been responded to
3 in the manner you would have wished for.

4 MS INNES: If we look on to the next page, we see the
5 response, I think, from the Chief Executive, so if we
6 look down, this is also dated 24 April 1990 and he
7 refers to -- a meeting that's taken place and he says:

8 'The purpose of this memorandum is to set down
9 an agenda for a further meeting between us which I will
10 arrange in early course.'

11 And if we go on to page 36, he -- if we go down to
12 under 'main issues'.

13 He says:

14 'A theme which recurs in the recent correspondence
15 is the reason for the now substantial body of
16 allegations of assault in Melville House, both
17 historically and in more recent times. The question is
18 raised as to whether there is a concerted campaign to
19 elicit complaints from former pupils of Melville House
20 or whether, in fact, the publicity given to
21 Melville House recently has simply brought forward
22 a number of new complaints which have hitherto not been
23 made. There is, of course, a range of further
24 possibilities.'

25 He says:

1 'I have to say that, irrespective of any thoughts
2 I might have on the origin of such complaints, this is
3 largely irrelevant. Complaints of any nature in
4 a setting such as this require to be looked into
5 rigorously, irrespective of whether the complaint itself
6 may be regarded as trivial or speculative. In short, we
7 do not have the luxury of treating these allegations as
8 anything other than seriously, with a full and rigorous
9 investigation in each case.'

10 And from what you've just said, James, you would
11 wholeheartedly agree with that, I think?

12 MR ROSS: Yeah.

13 MS INNES: Then if we go on over the page, he notes certain
14 concerns and expresses concern at (1) about
15 investigations in the past not being sufficiently
16 rigorous. And then, secondly, an inconsistency in
17 procedures adopted between the education and social work
18 departments and then he says that presumably complaints
19 should come under the same set of investigatory
20 procedures.

21 I assume that you would agree with that?

22 MS LLOYD: Yes.

23 MR ROSS: Yes.

24 MS INNES: Then he says:

25 'Most concerning of all, the recent correspondence

1 shows an apparent lack of mutual trust between the two
2 departments in their procedures and reveals what I can
3 only term a totally inadequate form of communication
4 between the two principal departments concerned when
5 they should be working together on issues of this type.
6 As far as I can see, the most recently investigatory
7 procedures have had to rely on my passing the relevant
8 reports to the other departments. This is clearly
9 unsatisfactory. Effective communication at the right
10 level between departments is a prerequisite to the
11 effective examination of complaints such as these.'

12 So again, there's an indication of there being
13 a breakdown in the relationship between the two
14 departments such that they weren't even speaking to each
15 other. They were having to speak to each other via the
16 Chief Executive. And you highlight this in your
17 response as being a systemic issue.

18 How do you guard against that now? How do you make
19 sure that your departments are working together
20 effectively?

21 MR ROSS: I think we have different governance arrangements
22 in Fife, we have the Child Protection Committee which
23 will address these issues and be, you know, a vehicle to
24 explore that. There's also -- we have Children in Fife
25 which is the children's services partnership and we have

1 the Corporate Parenting Board, so what we have is not
2 one service owning looked-after children or the care of
3 looked-after children, but a real partnership approach
4 to all of that and then what we have is multi-agency or
5 multi-service procedures for the protection of children.
6 And there is various subgroups that create those
7 documentations and processes and particularly the Child
8 Protection Committee also have a training subgroup that
9 cascade all of this to staff.

10 So what we've got is a removal from one service
11 being dominant and being able to dictate, but equally
12 having that kind of collaborative approach to addressing
13 safeguarding across systems and services and that now
14 gives us the strong position in the way in which we,
15 kind of, deal with allegations of abuse through the IRD
16 process and child protection procedures.

17 So -- and it removes -- and I think that's the bit
18 that I think is hugely important in the working
19 relationships that we all have -- is that it removes
20 professional hierarchy, or different professionalisms
21 being deemed to be more knowing or more powerful than
22 the other, and so that, kind of, collaborative approach,
23 through committees and structures and things, has
24 enabled us to move away from these practices to be in a
25 stronger position to safeguard young people when they

1 make disclosures.

2 LADY SMITH: James, can I just check I have picked you up

3 correctly with the entities you have mentioned?

4 Children in Fife is an entity. What is it?

5 MR ROSS: It's a -- it's all the partners that come together

6 to ensure that we have a children and services plan that

7 meets the needs of the most vulnerable.

8 LADY SMITH: So it's the overarching title for all your

9 children's services that come together in partnership?

10 MR ROSS: Yeah, but it looks at children where there's

11 vulnerability before we get to the area of child

12 protection. So Child Protection Committee focuses on

13 when an allegation has been made, but what we try to do

14 is have a partnership approach to addressing poverty,

15 vulnerability, children in need --

16 LADY SMITH: Sorry, can I just stop you there. I'm trying

17 to get these entities clear in my mind because you

18 rattled off a number of names. I got Children in Fife.

19 Then you said 'corporate parent on board'.

20 MR ROSS: Sorry, we have the Corporate Parenting Board.

21 LADY SMITH: The Corporate Parenting Board. So that's

22 another entity.

23 MR ROSS: Yeah.

24 LADY SMITH: And then you've got your Child Protection

25 Committee.

1 MR ROSS: Yeah.

2 LADY SMITH: With a training subgroup of that committee?

3 MR ROSS: Yeah, so we have a training subgroup of the

4 committee to ensure that all of our partners understand

5 the guidance process, procedures. Where there's gaps in

6 partnership working, we address that through that

7 subgroup. We also have a group that works on procedures

8 across different partners so that we're aligned to

9 working the same way, regardless of where the allegation

10 comes for children.

11 So we're probably -- it's a collaboration of

12 partners, there's a shared approach to developing

13 process and procedure and response, and it's not owned

14 or controlled by one service for the council or across

15 Fife.

16 LADY SMITH: Okay. I've got that.

17 But just going back to your idea of partnership, how

18 many partners are we talking about within that

19 partnership?

20 MR ROSS: So in the children's services, the Children in

21 Fife partnership we have representation from the

22 voluntary and third sector, we have health, we have

23 education, we have police, we have social work. So all

24 of the key stakeholders who would be involved in the

25 lives of children and their families are represented, at

1 all of these groups.

2 LADY SMITH: I can see why you regard them all as partners.

3 Do you actually formally bring them all together from

4 time to time to discuss matters of mutual interest?

5 MR ROSS: No, there's -- so that connection between all of

6 the groups is something that is not as strong as it

7 could be, so there's the potential for groups to work in

8 silo, and to develop things in silo, and what we have

9 tried to always have is a golden thread of service leads

10 that ensure that there's connectedness around all the

11 areas that we want to work on.

12 And we have clear plans that we progress, but

13 bringing all of the partners together to agree a common

14 approach to shared areas is something we're not as

15 strong as we could be.

16 LADY SMITH: Okay, thank you.

17 MS LLOYD: We do do some joint training though together,

18 where the partners do come round the table, so that

19 helps us in that relationship building and building of

20 trust. So we do try, but there are a number of

21 different boards, as you've understood, and it is quite

22 challenging sometimes to get the themes and everyone

23 understanding those aspects from the different outcomes

24 and we need to get better at joining those things up.

25 LADY SMITH: And you need to understand who is who, who is

1 the actual person to go to in relation to each area of
2 child protection practice and how to get to them.

3 MS LLOYD: I think for the child protection practice, which
4 mostly comes under the Child Protection Committee, we --
5 each -- each of the partners have a process in place
6 that is strong in terms of what we do. So I'm very
7 clear that schools would absolutely know who to go to,
8 who's the child protection co-ordinator within that
9 setting. I'm 100 percent clear on that, and I have it
10 from different reports, et cetera. So everybody knows
11 who to go to, so there's not a danger there.

12 I think the -- probably what we're referring to is
13 that in a big organisation, we have different aspects of
14 things that are dealing with similar things, but not the
15 same things and it's how we make the tie-up to all of
16 those to make sure we're getting the best outcomes for
17 the children and young people that we are privileged to
18 look after.

19 MR ROSS: I think the thing that I think is hugely important
20 is that it's the people closest to the children who can
21 escalate things and what we've got here is things being
22 escalated through a service that comes to directors. So
23 within Fife, we're very confident that if there's
24 an allegation of abuse, that the initial referral
25 discussion documentation can be completed by any

1 practitioner within Fife and that -- but generally it's
2 a joint discussion around the best course of action, and
3 I think -- so what we've got is people closest to
4 children who can surface concerns and then we've got
5 a really transparent way of investigating and
6 progressing action. But we also have always been really
7 clear about escalation policies. Professionals don't
8 always agree on the right course of action at that local
9 level, but that needs to be surfaced and we need to
10 understand that, because children can be harmed if the
11 agreed course of action isn't the agreed course of
12 action but the sense not shared. So again, we've got
13 robust processes within that, around the looked-after
14 review of children and child protection and within child
15 protection procedure. So I think that's hugely
16 important that we encourage the workforce to be -- know
17 each other and be strong and united in the sharing of
18 knowledge and the sharing of services to mitigate
19 against risk, but, equally, professional challenge is
20 healthy. We should encourage that, but we need to do
21 that in a way that's respectful and gets the best
22 outcome for the children and their families. So I think
23 those robust processes are in place rather than
24 hierarchical approaches that we see in some of this
25 documentation.

1 MS INNES: This is a slightly different question but is
2 based on some evidence that we've heard from academics.
3 So in this particular area, looking at children with
4 additional support needs or disabilities, they have told
5 us that there's a very complex legal and policy
6 position, as in policies could be found in health,
7 education, social work, disability policies that
8 transcend whether it's children or adults.
9 They raised concerns in relation to, you know, the
10 practitioner on the ground being able to appropriately
11 and quickly access all of the relevant material that
12 they would need to know about to assist a child who has
13 additional support needs.
14 I don't know if you've got any immediate reaction to
15 that?
16 MS LLOYD: So it would be interesting to know the research
17 because, you know, research can be interpreted in very
18 different ways.
19 What I can assure you is that all of our schools
20 have their additional support needs of every child and
21 young person. They have them noted. And they are
22 shared with all the staff in the school to understand
23 those, so they can act on them appropriately.
24 What I would say to you is, whether we act on them
25 and support them in the way that they maybe perhaps need

1 support is a different question. But actually, in terms
2 of knowing about the needs of the child or young person,
3 there are processes in schools, usually through
4 electronic systems that are flagged through CMIS that we
5 use. CMIS is a system for collating information in
6 education used by all 32 local authorities, so all the
7 information is flagged on that system.

8 The child protection information is flagged slightly
9 differently and there's limited access to the child
10 protection cases but, in terms of additional support
11 needs, that information is available to all staff in the
12 school.

13 Where we do sometimes get criticised is it's not
14 always available to the non-teaching staff, because they
15 often don't have access to IT provision and nowadays it
16 tends to be in the IT provision that we have that
17 information, but we do have plans for children and young
18 people in terms of meeting their additional needs,
19 et cetera.

20 But as you know, there has been a rise in recorded
21 additional needs across Scotland, so that gives way to
22 lots more need and that need can be under, I think it's
23 approximately 27 categories, which includes bereavement,
24 family issues to dyslexia, dyspraxia, neurodiversity, et
25 cetera, so -- but that information is there and is

1 available on all of our schools and settings in Fife.

2 MR ROSS: I suppose what I think is really important to be
3 clear about is that child protection procedures,
4 training, guidance apply to all children irrespective of
5 their additional support needs. Where children have
6 complex disability, often unable to express a view and
7 opinion, then we have additional training for staff
8 because there is a different way in which they have to
9 have that extra vigilance around the practices that they
10 have to undertake.

11 But it's a complex area of work. One that I think
12 we still have to continuously reinforce with staff
13 around confidence and competence in that area. But, you
14 know, we have a children affected by disability social
15 work team because we know there is a specialism required
16 to support and plan and advocate for those children and
17 their parents and carers. So I think we're probably in
18 a different position now than we historically were, but
19 we appreciate different groups of children need
20 different things.

21 We have a process and procedure that underpins that,
22 but the practice might need to look different in terms
23 of how we investigate, how we speak to children, how we
24 can gather an assessment of their needs without them
25 articulating that.

1 So -- but again, you know, we would be confident
2 that's an ongoing journey of improvement that we need to
3 commit to and I think we now recognise that children who
4 are looked after have additional support needs in a way
5 that we didn't before.

6 So I think for me it's really important that all of
7 the processing of procedures that we have developed in
8 Fife are applied to all of the groups of children, that
9 not one group is seen as different or exempt from that,
10 because if not, they're not applying the same rigour to
11 all of the children who are vulnerable.

12 MS LLOYD: We probably do though in our five special
13 schools -- we've always had a process which was always
14 perhaps phoning through to social work that bit quicker
15 to support us, because working alongside the
16 professionals that work with them, they know how to get
17 the information from the child and young person in the
18 best way possible in terms of using Boardmaker,
19 et cetera, in which they are able to show pictures,
20 et cetera.

21 And we've always, actually for quite a number of
22 years, had that access to -- immediate access to a phone
23 call with social work, which makes it quite a quick
24 response as well because what we've got to remember then
25 is that they are a particularly vulnerable group. So

1 that level of complexity within additional needs, we
2 have always dealt with in a kind of more particular way
3 because we need more support round about those areas.
4 But actually that's been probably in the last --
5 certainly since I've been there for the last six years,
6 that's been one of the strengths of the way in which we
7 work with social work at that point and a particular
8 disability team that have always been in place in Fife
9 to support that.

10 MS INNES: One of the things that we've heard evidence about
11 is that there's a potential danger of ascribing -- of
12 interpreting behaviour of children with additional
13 support needs in a particular way.

14 So the behaviour -- there's a danger of saying,
15 well, that's just the way they behave, as opposed to
16 seeing that as a reaction to a potentially abusive
17 situation. Is that something that you would agree with
18 or not?

19 MS LLOYD: I think that we have, over the years, invested
20 a lot in our training for additional support needs and
21 tried to understand and I think we try to build really
22 strong relationships with the children and the staff
23 that they work with.

24 When I refer to the special schools, I think, in
25 particular, that's an area in which it tends to be the

1 same staff working with the same children, so they do
2 see changes all the time and anything that they see as
3 a change, they are inquisitive about. So I think there
4 is. However, I do think that when it's demonstrating,
5 you know, more -- you know, if you've got somebody maybe
6 perhaps with ADHD or autism, et cetera, I think some
7 staff could, when they see a certain behaviour,
8 attribute it to the additional need rather than to the
9 fact that there's a change in behaviour, and that's what
10 we've been mentioning before about that change in
11 communication. That's why it's vitally important to us
12 that it's people who know the children and the families
13 really well to be able to identify those changes,
14 because sometimes changes are brought on by something
15 that's maybe happened at home, a different routine,
16 a change because this affects young people in different
17 ways.

18 MR ROSS: I think it's such a complex area, because the
19 range of diagnosis and conditions that children can have
20 can be multiple and just exceptionally complex. But
21 you're right, it's around how do we create a workforce
22 that has professional curiosity to have a knowledge base
23 to understand a diagnosis and the behaviours that might
24 be attributed to that, but equally have professional
25 curiosity to understand there might be a different

1 reason for behaviour, and I suppose that's the role of
2 governance within particularly the social work
3 structures that are important.

4 So we have what we would call in Fife a resource
5 panel and social workers come to discuss
6 recommendations. What I'm very positive about is that
7 they would experience rigour, it -- that -- and that's
8 about us all trying to use professional expertise to
9 understand the behaviour, the complexity and share
10 knowledge, practice, wisdom and have colleagues from
11 education there.

12 I think one of the things that we've realised where
13 there's a real gap is we're about to introduce a complex
14 case panel because what we need is professionals from
15 multiple disciplines to bring their expertise to
16 understand the child's circumstances and often the
17 social worker is not the best person or the only person
18 that can do that and that runs us into risks of
19 misinterpreting what's before us.

20 So again, as we just need to be, I think, mindful of
21 the complexity and ensure that there is a range of ways
22 in which we support the workforce to be curious, but to
23 be skilled enough to understand what is being presented
24 before them.

25 MS LLOYD: I think in addition to that, you know, we

1 referred earlier on to psychologists. We have a team of
2 educational psychologists and part of their role,
3 approximately 20 to 30 percent, is to read and update
4 themselves on research and to share that research with
5 other professionals to ensure that we are up to date and
6 often they lead a lot of the training for our --
7 particularly within our settings in our schools, so that
8 people are better informed. So research changes all the
9 time and we need to, you know -- in education, we say
10 learning is part of everything we do, so we need to keep
11 learning and moving forward in any new information we
12 get.

13 LADY SMITH: You mentioned the desire to inspire curiosity
14 amongst professional staff. Is it also a matter of
15 inspiring aspiration amongst them, aspiration to both
16 educate the child and enable the child to flourish as
17 well as that child, with its particular characteristics,
18 can?

19 MS LLOYD: Yes. I mean, I think that aspiration's a keyword
20 that I'm using a lot in education, because outcomes for
21 Fife young people generally are not as good as they
22 should be. They'll never be as good as they should be
23 for me, because -- until they get 100 percent. I just
24 want to say that, I can't help that, teacher part of me.
25 But we also are very aware and mindful that those who

1 have had any care experience do less well than their
2 peers.

3 We know that for a variety of reasons. We know that
4 they leave school earlier than their peers. We also
5 know that their outcomes are -- in particular in things
6 like National 5s and Highers, for those of you in the
7 audience who are a bit older, the equivalent of O-Grades
8 and Highers, et cetera, that they're not as good as
9 their peers. And in some cases that's going on to
10 university, for example, is 25 percent below their
11 peers. So there's lots more work to be done with what
12 is quite a small population.

13 They attend our schools well. They are only
14 1 percent only -- sorry, 1 percent behind their peers.
15 Exclusion rates are higher for care-experienced young
16 children, despite lots of effort that we are making to
17 change culture, and their outcomes are generally poorer,
18 except for going on to further education, where they are
19 higher than their peers and higher than Scotland in
20 Fife, as all FE is, but also they tend to go there after
21 fourth year at school. So they leave and they go on to
22 further education. I think it's something like
23 53 percent go on to that.

24 Some of that's because we don't have a curriculum to
25 meet the needs. Some of it is because of the trauma

1 that actually they want to come out of an institute and
2 go somewhere that's perhaps more -- they're treated more
3 as an adult and an individual because school isn't for
4 everyone. There's also a financial aspect to that also
5 because of the finance that is given once you move on to
6 FE as well, if you are care-experienced and looked
7 after.

8 Quick answer is aspiration is key and we need to be
9 aspiring for all of our children and young people to get
10 the very best to prepare them for the world of work,
11 life and learning.

12 MR ROSS: I suppose for me it's about how aspirational we
13 are for families so that children come through the care
14 system less and, certainly, we know in Fife we've made
15 significant progress in that. But it's how we
16 understand poverty, how we understand deprivation, how
17 that impacts on parents and their own aspirations, but
18 how do we have a workforce that's aspirational so that
19 the impact of care, if you're not abusing the care
20 system, there's still a significant impact of care on
21 your life. So where possible, how can we sustain
22 children within their families and that we have
23 aspirations for parents and we don't have a view of
24 poverty writes people off.

25 So I think you're right, all of that needs to be

1 taken into consideration, but the key to this is
2 a confident, competent, skilled workforce that can do
3 comprehensive specialist assessments and plan with our
4 partners to respond to the complexities in families'
5 lives.

6 LADY SMITH: Thank you.

7 MS INNES: Now, going back to the Part B response, at
8 FIC-0000001182, at page 67.

9 We were talking about the 1990/1991 period when some
10 allegations were considered.

11 Then it tells us that there was another
12 investigation, I think, in the course of 1997; is that
13 correct?

14 MS LLOYD: Yes. There was an internal Fife investigation at
15 that point.

16 MS INNES: We can see that it says that:

17 '[It] concluded that [there was] they didn't find
18 evidence of incidences of deliberate abuse of children.
19 However [and this is at Melville House] there was
20 an ethos of physical contact between boys and male
21 staff, which had the potential for misuse of physical
22 force. There was corroborating evidence for some of the
23 allegations made but the investigation concluded that
24 these were not examples of practices that were
25 widespread.'

1 So one of the focuses or the outcomes of this
2 investigation appears to have been in relation to the
3 use of inappropriate restraint, and I assume that that's
4 an area that you're continuing to work on. Obviously we
5 know that there's been more recent guidance issued by
6 Scottish Government in relation to this.

7 MS LLOYD: Yes. It's come up several times in the
8 Melville House. We are currently, within education at
9 the moment, reviewing our current physical intervention
10 policy. It's probably -- not probably, it is also in
11 light of the Bill that's currently in -- we know going
12 through the Scottish Parliament with, I think it's MSP
13 David Johnston, so we are looking at that in light of it
14 and certainly the things coming out is -- are round
15 about not reporting to parents or carers quickly enough.
16 Not recording the absolute detail of the restraint or
17 physical intervention that's taken place.

18 In Fife, we are starting to move away from what we
19 used to have as CALM training in the education and
20 looking more towards escape training, which is less
21 intervention and more moving away from the situation in
22 place, but certainly we analyse our restraint,
23 physically and particularly round about restraint
24 interventions regarding children and young people. But
25 we need to look at it -- you know, the whole perspective

1 and at the moment that's what we're doing, because our
2 policy is needing updated.

3 MR ROSS: I think within care we've made significant
4 progress in recent years in the fact that we have
5 a clear commitment to where, as much as possible, that
6 we do not have our hands on the children and young
7 people that we have in our care and that the aspect of
8 our training is around recognising triggers for
9 de-escalation so that restraint does not become
10 commonplace.

11 But I think more importantly around -- for me is
12 around the gathering of the data. So we know all of the
13 restraints at our houses, we have professional curiosity
14 into understanding what led to that restraint and what
15 needs to change in the care plan for that young person
16 that would mean future restraint was not possible, or is
17 it something about the staff and what they need so that
18 they feel more equipped to respond to trauma rather than
19 a physical hold.

20 I'm always curious about is it the same staff all of
21 the time on the rota and what does that tell us? So we
22 thoroughly examine that level of restraint, but we're
23 really comprehensive in our paperwork, so we have
24 the debrief, we explore the need to change care plans,
25 risk management plans and sometimes about just

1 upskilling the staff through a reflective conversation
2 about what could have been done differently that would
3 have prevented that.

4 I suppose I go back to my career -- my early job as
5 a residential social worker, to hear children being
6 restrained is actually very distressing for the staff to
7 hear that, there's nothing good comes out of that and
8 it's very damaging, and young people have always told us
9 that. So again, whilst we have a clearer vision but we
10 need to make sure that our staff are emotionally
11 contained, but they're also skilled enough to manage the
12 identification of escalating behaviour so that we're
13 much more nurturing in the response so that we require
14 less physical intervention. But it's -- without the
15 change in legislation, we're really clear that that's
16 not a practice that we would want in our houses. So
17 a quality assurance lends an approach, that means that
18 we've brought the figures down quite significantly and
19 we still promote CALM on all levels, but we're clear to
20 our staff it's about understanding de-escalation, and
21 it's not permission to restrain.

22 LADY SMITH: Maria, you mentioned escape training as opposed
23 to restraint. If you're using a process, an escape
24 process rather than a restraint process, what are you
25 doing? What happens?

1 MS LLOYD: So I'm not an expert on this.

2 LADY SMITH: Well, what's your understanding, let me put it
3 this way?

4 MS LLOYD: My understanding, and it's a move we're moving
5 towards, is so that we actually leave the child in
6 an environment that, yes, they might destroy property,
7 but they're not going to come in danger as we're --
8 quite often in the past, restraint has been -- you know,
9 it's supposed to be the last resort for, you know,
10 preventing, you know, injury to themselves or others,
11 but on some occasions people have felt that that applies
12 to chairs or equipment or -- et cetera, and it shouldn't
13 as long as they're not at risk themselves.

14 So it's more of -- it's the same as what James is
15 saying really, it's about de-escalation, it's about
16 moving away, knowing the triggers, not kind of
17 escalating the aggravation that perhaps the child is
18 already in and moving away from it, because sometimes
19 an adult moving themselves away from the situation
20 actually calms the situation down to just kind of -- so
21 that's -- it's more about moving towards a different
22 technique and of course we're talking about restraint.
23 The physical intervention bit can also sometimes be
24 quite positive because we need to remember that, you
25 know, physical intervention can be a child removing

1 themselves from a situation or an adult helping them to
2 remove themselves from a difficult situation. It's not
3 always just restraint. There's aspects of that that can
4 actually help self-regulation as well of a child or
5 a young person.

6 LADY SMITH: Just going back to escape, and I think
7 I've heard it described a little differently before,
8 you're talking about when you can leave the child really
9 to work through their own storm and that will be the
10 quickest way through?

11 MS LLOYD: Yeah, it might just be backing off, for example,
12 rather than always -- I think it's what James is saying
13 about that thinking differently. It's about the
14 triggers, but there's always going to be children and
15 young people who, you know, express themselves in a way
16 that you, you know, that they need to be -- needed
17 calming, but it's deciding what that -- is right for
18 that child or young person. So the escape training
19 seems to be something that is being explored as perhaps
20 a way forward within education, because we use it not
21 a lot in education, because we do not train just every
22 member of staff in CALM, because we don't expect it to
23 be used in mainstream schools. We use it in special
24 schools only and in what's called our pupil support
25 service, which is when some of our children and young

1 people are part-time maybe at a mainstream school and
2 part-time at a pupil support service, which is smaller
3 class sizes, more support for the young person,
4 one-to-two, one-to-one sometimes. It can be
5 an in-between, between residential or secure, et cetera.
6 So that's the people that are trained in it. So we
7 don't train all of our staff in it, we only train
8 special schools and PSS staff in it in terms of
9 education.

10 LADY SMITH: Thank you. Ms Innes.

11 MS INNES: Can we move on, please, to page 68 and
12 paragraph 3.2. Again, this is in relation to
13 Melville House:

14 'Does the organisation accept that its systems
15 failed to protect children cared for at the
16 establishment from abuse?'

17 And the answer to that is: 'Yes', and I think you
18 highlight below, and you've already highlighted in your
19 evidence, a number of systemic issues that you've set
20 out in your response.

21 MS LLOYD: Yes.

22 MS INNES: Then in terms of response to abuse at page 70,
23 paragraph 3.3, you also accept that there were failures
24 and deficiencies in response to abuse at Melville House;
25 is that right?

1 MS LLOYD: Yes.

2 You referred a moment ago in your evidence to the
3 current provision that you have.

4 So we understand that Fife no longer provides
5 residential education for children; is that right?

6 MR ROSS: Yes.

7 MS INNES: And then we understand, from information provided
8 to the Inquiry by your solicitors today, that there are
9 now ten residential houses?

10 MR ROSS: Yes.

11 MS INNES: And these are of varying capacity, but for --
12 presumably these are for children who are in care but
13 might be attending school or will be attending school
14 somewhere else?

15 MR ROSS: Yes. So if they live in a community house and
16 have access to either mainstream education or a
17 specialist provision in the community.

18 MS INNES: We understand that there's an intention to expand
19 these facilities, so small houses?

20 MR ROSS: Yes. We currently have ten houses and we've tried
21 to cap them as four-bedded houses and we're about to
22 establish a transformational care board, where we're
23 looking to move to two-bedded houses and that's been
24 very aspirational, but that is certainly the vision that
25 I've got for our service. We recognise that we deal

1 with young people with complex trauma and group living
2 is not for most of us, never mind for young people who
3 are away from their families. So we have now, in our
4 capital plan, about to build a further three singleton
5 placements where we think we can give young people the
6 best care, attention and really informed responses to
7 stabilise them and to use that stability to inform
8 future planning.

9 But we have -- also have a desire to not -- not to
10 use secure care and we know that singleton placements
11 may allow us to move away from secure care, but we also
12 want to keep our children in Fife where they can keep
13 connections, particularly with their families. So we
14 have got a real aspirational vision for our residential
15 childcare provision, both of the current houses but also
16 in our capital plan as we look to expand.

17 But that's about understanding the trauma that group
18 living can bring on to children and how that trauma
19 sometimes is not well understood and creates a plan for
20 children that means longer term care becomes the plan
21 for them.

22 So -- but I come from a background of residential
23 social work and thoroughly enjoyed my time in that, but
24 have been steeped in understanding the complexities of
25 delivering group care, but also recognising the impact

1 that has on children, and so we're really keen to move
2 away from that in Fife to as close to small households,
3 central to the community and central to the community
4 that they lived in.

5 MS INNES: We understand that you did provide information in
6 the original A to D response saying that you offered
7 respite care to children with disabilities, but
8 I understand, from the information provided, that you
9 don't run these respite services internally anymore. So
10 presumably there are, perhaps, respite services operated
11 by other agencies or bodies?

12 MR ROSS: Yes, we had two houses that operated respite care.
13 The demand was low in Fife when we reviewed those and we
14 now commission all of our respite care from Aberlour and
15 that operates within Fife and they're our only provider
16 of respite care.

17 LADY SMITH: They've been operating in Fife for quite
18 a while.

19 MR ROSS: Very well-established service, you know, very
20 positive feedback from families and we know that they're
21 skilled in dealing with a population of children that at
22 times we were unable to manage that need as effectively.
23 So -- but equally, by reprovisioning the respite
24 provision, we were able to bring children with very
25 complex needs back into Fife and that gave us assurance

1 that their needs were being met in a way that we felt
2 they hadn't been previously.

3 MS INNES: Now, I want to ask you about a separate matter,
4 which is material that Fife Council provided to us in
5 relation to Starley Hall, which we understand to be
6 an independent school in Fife and we understand that
7 round about the time that the 1995 Act came into force,
8 just before that, there was a provision for voluntary
9 registration of such services with the local authority
10 for inspection purposes, and then that it became
11 compulsory from the implementation of section 34 of the
12 1995 Act, which came into force on 1 April 1997.

13 Now, I understand that, James, you've had
14 an opportunity to look at some of the documents that
15 were provided in relation to this; is that right?

16 MR ROSS: Yes.

17 MS INNES: If we can look at FIC-000001502.

18 And this is a memo from 17 August 1995 about the
19 registration of Starley Hall and it's from the Director
20 of Social Work -- sorry, it's to the Director of Social
21 Work from Mr Findlay, who was then head of the
22 Inspection Registration and Client Relations Unit, so
23 the unit that was going to carry out the inspections at
24 the time. He says that he's been forwarded a copy of
25 the letter from the headmaster of Starley Hall.

1 But the letter had, in fact, come from the Chief
2 Inspector of Schools where the Chief Inspector had said
3 there was an urgent need to progress the intention to
4 seek social work registration for Starley Hall.

5 And Sue Wilkinson, who we understand worked for
6 Fife, had spoken to Alistair Marquis, who's
7 an inspector, who said he had many concerns about the
8 safety and welfare of children at the school and he was
9 then going to meet with people to discuss how to take
10 this forward.

11 So I think that was the first letter that Fife were
12 able to find in relation to this issue of registration;
13 is that right?

14 MR ROSS: Yes.

15 MS INNES: And then if we look at FIC-000001466, there's
16 a letter dated 13 March 1998 to the Chief Inspector of
17 Schools from Mr Findlay and it appears from this letter
18 that a person has made allegations against -- well, in
19 respect of the time he was at Starley Hall, and at the
20 bottom paragraph it says:

21 'Starley Hall has not yet been registered but KYU-SNR
22 KYU-SNR has had a series of discussions with Sue
23 Wilkinson, who has made several visits to the school.
24 Concerns about allegations of assault which were sent to
25 the Procurator Fiscal last summer and the standard of

1 accommodation in the main house and lodge are hampering
2 the process. [REDACTED] was asked by letter in
3 February 1998 to complete an application as soon as
4 possible.'

5 Now, I'm not sure whether you had any further
6 understanding, James, as to why it was that it took so
7 long for the registration process of Starley Hall to go
8 through?

9 MR ROSS: It's hard to give comments because I haven't been
10 able to see any other information that would allow me to
11 just maybe fully understand the context.

12 MS INNES: So it does look as though from -- all we can see
13 from this letter is that there were some allegations,
14 there were issues about the building.

15 Then if we look on to FIC-000001472, this is
16 an announced inspection in 1998. Now, we've looked at
17 this document in other evidence to the Inquiry before,
18 but perhaps if we look at page 6, there we see a number
19 of recommendations being made.

20 For example, 2.6:

21 'Immediate action to improve the safety of young
22 people must be taken.'

23 That's one of the recommendations. If we go to
24 page 33, we see the conclusions at 6.8, at the bottom of
25 the page, where it says:

1 'In conclusion, the quality of residential
2 experience at Starley Hall was very poor for some young
3 people. There is a general lack of homely atmosphere
4 and little evidence of encouragement for the young
5 people to spend time in their home. The staff seemed to
6 spend a great deal of time reacting to incidents and
7 there seemed to be no overall focus on promoting normal
8 homely activities.

9 'Although some social workers made favourable
10 comments about progress, the evidence of the
11 questionnaires and the observations of the inspection
12 officers suggest that children are bullied and staff do
13 not know how to respond to this.'

14 There's an issue about the mix of children:

15 'There's a need to provide a much more homely base.'

16 And then the final sentence:

17 'The highest priority must be given to ensuring the
18 safety of children and young people.'

19 What were your thoughts when you considered this
20 inspection report?

21 MR ROSS: I suppose, it would be fair to say there was a
22 huge concern by the inspectors on a number of areas, one
23 around the, kind of, physical condition, the confidence
24 and competence of the staff and the detail of care plans
25 being absent to support those staff to respond to what

1 was complex needs.

2 And ultimately, I suppose, it was around, for me,
3 what was the intention of Starley Hall to offer. So
4 what was the hopes and aspirations for the service and
5 what was the young people that they felt they could
6 match into the skill set of their staff in -- and that
7 clearly this was -- you know, these were large buildings
8 that had been taken over by Starley to become
9 residential children's homes, but it was still in a --
10 it still had a long way to go to get to that point of
11 being fully developed.

12 MS INNES: And if we go on to FIC-000001479, we can see that
13 there was a communication from Fife to the Chief
14 Inspector of Schools on 31 July 1998, noting the
15 application to register and asking if HMIe had any
16 objection to registration. So trying to gather some
17 information from them?

18 And then if we look on to FIC-000001481 and if we
19 look on to page 5 and down towards the bottom of the
20 page, under 'Recommendations', it says:

21 'There have been unproven concerns [and that's about
22 KYU-SNR] who has faced allegations of assault.
23 The Procurator Fiscal does not intend to proceed.
24 An inspection in May 1998 identified concerns over the
25 safety of young people, particularly in relation to

1 bullying and the state of the premises.'

2 So that's the inspection report we've just looked
3 at.

4 'Changes to the premises have been made and they are
5 now satisfactory. It is my view that the only way to
6 monitor and improve Starley Hall is through registration
7 and regular inspection. As KYU-SNR has made
8 a determined effort to improve the premises, and has
9 appointed qualified social workers, developed a training
10 programme and anti-bullying strategy, I have sufficient
11 evidence to recommend approval with conditions for
12 a school with a certain number of places.'

13 And then there are conditions mentioned and, at the
14 top of page 6, the first condition is that:

15 'The inspection and registration officer must be
16 notified immediately of all serious incidents or
17 complaints involving allegations of sexual, financial,
18 physical or emotional abuse, bullying or inadequate
19 care.'

20 So it appears that the recommendation of the
21 inspector was that they had sufficient at this stage to
22 register the service, albeit there's this particular
23 condition imposed.

24 MR ROSS: And the two things can appear contradictory when
25 you read them. I suppose what I took from this document

1 was that, given that the local authority had very little
2 locus prior, that the aim was really to have them
3 registered so that there was a greater opportunity for
4 the local authority to have an influence over the future
5 delivery of the care at Starley Hall because it is
6 an unusual condition to apply that these incidents, you
7 know, so specifically are named to be notified to the
8 local authority.

9 You would -- so there was some suggestion by the
10 inspector in the approval process that these were issues
11 that were likely to occur.

12 MS INNES: Yes, because we've had a concern expressed by the
13 parent of a child who was at Starley Hall, who's had
14 access to this material, that the school was registered
15 with this background; and what's the council's response
16 to that?

17 MR ROSS: I suppose we would always want to reflect and
18 I think -- the intention would never have been for
19 a child or young person to have experienced what they
20 have experienced and certainly the intention, I believe,
21 of the local authority at that point was to have some
22 control and rigour over Starley Hall in a way they
23 hadn't done previously.

24 But as a consequence perhaps of what might appear to
25 be a lack of transparency around that, we have not fully

1 owned the concerns that are around about the caring
2 practices of the staff. So there is -- you know, the
3 two things are contradictory in their terms and we have
4 to own that and accept that and we have to, I think,
5 acknowledge that, in doing so, that we have potentially
6 posed a risk to children by not having tight safeguards
7 around the caring practices.

8 MS INNES: Do you know what enforcement powers the local
9 authority would have had at this time? You mentioned
10 earlier that, obviously, the Care Inspectorate had
11 enforcement powers, and we have looked at some
12 inspections at an earlier stage where there wasn't that
13 follow through?

14 MR ROSS: That's something I don't know, sorry.

15 MS INNES: Is Starley Hall a school that Fife have worked
16 with over the years? You mentioned that you commission
17 placements from Aberlour, but obviously Starley Hall is
18 also in your region?

19 MR ROSS: Yeah, we, obviously, as a local authority,
20 commission placements with a range of providers and
21 Starley Hall, we've had a relationship where we've had
22 children placed there at various points over the years.
23 For quite some time, it's been low in numbers because
24 we've always had the desire to, where possible, care for
25 children in their own houses. So we've got -- we

1 limited the number of children with them.

2 MS INNES: When you are commissioning placements for
3 children, do you carry out some kind of independent
4 assessment of that provider or whether that matches with
5 the child that you're wanting to place?

6 MR ROSS: Yeah, we've always, until recently, had
7 a placement commissioner. It was a role that was quite
8 unique to Fife. So we examine all of the
9 Care Inspectorate inspections and understand the quality
10 of the provision from their lens.

11 We used to have six-monthly meetings with the
12 providers to understand just the state of the play and
13 challenges and what could we do to support them, and we
14 always, sort of, feed back from social workers who had
15 children placed in advance of our meeting with them, and
16 we visited, six months or so that we had intelligence
17 internally that might be helpful to have a more rigorous
18 discussion. So that was a role we had up until just
19 about a year ago.

20 We've moved away from that on the basis that we have
21 a very small number of children placed in external
22 providers, but I now review all of our children in
23 residential care, both internally and externally, on
24 a monthly basis. And I am always keen to understand
25 what children are receiving and I bring together

1 multiple people from a leadership team who are not
2 purely operations, so that we have a reflective
3 conversation of: is this provision meeting the needs of
4 the child? What's their progress? I need to be assured
5 of the care and I used to be commissioner as a service
6 manager in Fife so I have a knowledge of all of the
7 provision internally and externally and I use that to
8 make sure that I am confident, being so removed from
9 children, that we're objective in questioning and
10 challenging the care that we've got, and being assured
11 that at all times that the environment is meeting the
12 needs of the children, particularly as they grow and
13 develop.

14 MS INNES: Just finally to each of you, and you may well
15 have covered everything that you wanted to say about
16 this in the course of your evidence already, I think
17 both of you have mentioned that, over the course of this
18 review, of reviewing the material in relation to these
19 institutions, even although they're closed now, there's
20 various reflections and learning that you are taking
21 away from that process.

22 I know that you've highlighted some of those as
23 we've been going through. I just wanted to check if
24 there was anything else or particular that you wanted to
25 highlight in terms of that learning.

1 MR ROSS: I think from a kind of social work perspective,
2 I think what we -- when we remove children from their
3 families, what we'd hope is that we can provide
4 something that's -- that will meet their needs, keep
5 them safe and achieve their best in life and
6 unfortunately for children from these houses, we know
7 that the opposite has happened.

8 So I think as a local authority, I think we're
9 deeply sorry about the impact that life and these events
10 had on these young people's lives forever and their
11 extended family, but the reflections and learning for
12 us, both in this process and over recent years as we've
13 engaged in the Inquiry, is around being much more
14 confident in our safeguarding policies and procedures,
15 how we are assured of the quality of the care, that we
16 have evolved our processes and our services to ensure
17 that the voice of the child and their family, I think,
18 is listened to, is heard and is acted upon and I think
19 we've made huge strides in ensuring that we try to have
20 a quality of care provision for children that is small,
21 that's trauma-informed, that's nurturing, but we also
22 have scrutiny over the care that the children receive in
23 those houses, albeit they're owned by the local
24 authority.

25 And I think where we've also got, in terms of our

1 reflections, is that we've made huge strides in our
2 approach to move away from a position where we believe
3 the views of adults only and that we've moved in Fife to
4 a really strong child protection process. We've got
5 a strong interviewing team. We adopted SCIM quickly in
6 Fife and we are now a Bairns' Hoose pathfinder. So
7 I think we've always acknowledged that practices fell
8 short in the past, but we have got a commitment to
9 ensure that the experiences of people over the decades
10 are used to improve the services that we deliver.

11 And we wouldn't be sitting here claiming that we've
12 got everything right now and that there's no more
13 improvement to be made, but that's a journey that we're
14 on and that we're committed to, but we have to ensure
15 that when children are removed from their family or the
16 family can't care for them, that what they get is the
17 best care possible, and that they do the best in life
18 through our support. But at all costs, we support the
19 family to have that child returned and that's become the
20 vision and strategy of Fife.

21 So, you know, it's very hard to hear the witness
22 testimonies and to understand that real life impact, but
23 all of that is something that we're engaged in, we've
24 taken on board, the learning and I think we've made huge
25 progress in, in acknowledging through the Redress Scheme

1 that financial compensation is almost irrelevant in all
2 of this.

3 What we have to give is heartfelt apologies to
4 people who have been abused and their lives have been
5 impacted and we can give them the reassurance that what
6 we've done has made a difference. What they've said has
7 made a difference to the lives of people who find
8 themselves in care now.

9 MS LLOYD: I think I probably echo everything that James has
10 said and probably from the educational perspective and
11 probably what you have touched on today, we need to
12 always be questioning the culture. Because cultures can
13 change very quickly, depending on the leadership and the
14 relationships between, as we've heard through this,
15 through Social Work and Education.

16 As you can probably see from ourselves today, we
17 work very closely together, but we need to ensure that,
18 when we're not around, that that relationship and that
19 professionalism and respect and positive culture that's
20 about the needs of children and young people and the
21 values base, we need to ensure that that continues in
22 everything we do through our training, through our
23 practice and through how we behave and role model and
24 act, but I think there's definitely some learning for us
25 round about some of the quality assurance. There's

1 still kids not getting enough of an educational
2 experience who are in our current homes and we know the
3 impact that that has long-term on outcomes for the
4 future.

5 So there's still learning for us and probably after
6 we digest today, there will be more that we could have
7 or wanted to say, but please be assured that we will
8 take learning from this, we'll go back with some of our
9 colleagues, we have got one of them here today, to look
10 at our practices and reflect on it, but we are deeply
11 sorry for the impact that this has had on children and
12 young people.

13 MS INNES: Thank you very much.

14 I have got no more questions for you.

15 LADY SMITH: Maria, James let me just add my thanks.

16 I'm really grateful to you for coming here today and
17 being able to discuss everything we've discussed so
18 frankly and openly. It's been of enormous value to me
19 to hear that and be able to engage with you, as we have
20 done.

21 As you say, there's a lot for you to digest.
22 There's a lot for us to digest as well, but I think we
23 will all go away feeling that today has been of great
24 benefit to us for our particular purposes.

25 So feel free to go. I hope you don't have to go

1 back to work now. Draw breath before tomorrow. Thank
2 you.

3 MS LLOYD: Thank you.

4 (The witnesses withdrew)

5 LADY SMITH: Ms Innes.

6 MS INNES: So, my Lady, that concludes the evidence for this
7 block of hearings.

8 We are not leaving Fife schools behind. Starting on
9 8 July, we will have two weeks of hearings during the
10 course of which, we will hear from staff members at some
11 of the five schools that we've been looking at:
12 Starley Hall, Woodfield Ladymary, the schools that we've
13 looked at in this block of evidence and we'll also turn
14 our attention to Lendrick Muir, Seamab.

15 LADY SMITH: Indeed. Well, thank you very much, and I look
16 forward to engaging with everybody on 8 July. Thank
17 you.

18 (3.13 pm)

19 (The Inquiry adjourned until 10.00 am
20 on Tuesday, 8 July 2025)

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