Scottish Child Abuse Inquiry

Witness Statement of

Tom SHAW

Support person present: no

1. My name is Tom Shaw. My date of birth is [redacted] 1940. I am retired.

2. This statement is based on my recollection aided by documents. I have seen documents provided to me by the Inquiry.

Previous witness statement

3. I provided a witness statement dated 12 January 2019 to the Inquiry. The purpose of that statement was to provide an overview of my involvement as Chair of a pilot private confidential forum known as "Time To Be Heard" ("TTBH").

Qualifications and professional experience

4. My qualifications and professional experience are set out in paragraphs 3 to 12 of my previous witness statement.

Historical Abuse Systemic Review (the "Review")

5. Before my involvement with TTBH, I led an independent review known as the "Historical Abuse Systemic Review". The Review was conducted between August 2005 and November 2007. A report of the Review was published in November 2007.

6. The Scottish Executive wanted a mainly desk-based review of the systems and arrangements in place in Scotland from 1950 to 1995 that were intended to protect children who were placed in residential establishments. The Review was not, and was not intended to be, a forum to hear the experiences of former residents.

Process of appointment, remit and research support

7. In spring 2005, I was contacted by Rachel Edgar, an officer of the Scottish Executive Education Department (SEED) and asked if I would be willing to lead the review. I was formally appointed in August 2005. The remit I was given is set out at pages 10 and 11 of the Review report. I had no input into the remit and did not meet the Education Minister, Peter Peacock, until 2006. I had very limited powers and depended largely on the co-operation and goodwill of those who might have information that would assist me to fulfil my remit.

8. Under the initial remit I was able to talk to people in local authorities and other organisations with responsibility for the management and administration of residential schools and children's homes. I was also permitted to obtain information from organisations representing the interests of survivors of abuse. Driven by considerations of fairness, I wanted to be able to talk directly to former residents. In 2006 I made a request to do so to the Education Minister and this was granted.

9. Rachel Edgar indicated that the Review might involve two or three days a week for up to a year with support from a part-time research assistant. Assumptions about the files which the Review might need access to

suggested no awareness of the fact that there were many other files, including confidential files, within the National Archives of Scotland (NAS) that we would need to access. I do not think it was anticipated that much time would also be required to contact and communicate with people. Additionally, there may have been a state of ignorance about the complexity of the legal and regulatory framework between 1950 and 1995 and how it operated in practice.

10. At the outset I had one part-time research assistant, Nancy Bell. In mid-2006 I was permitted to employ a legal researcher, Roddy Hart. His research focused on the historical legal and regulatory framework.

No central register of establishments

11. There was no central register of children's residential establishments operating between 1950 and 1995. I found that astonishing.

12. We started to build up a register but were not able to make a comprehensive record by the time of completion of the Review. My hope was that the Scottish Government would take on the responsibility of completing this exercise, especially for the benefit of former residents in establishments that had long since closed. Many small, privately run establishments had closed down during the period covered by the Review.

Engagement with Scottish Government during the review

13. I had regular contact with officials of SEED and, soon after my appointment, was briefed by a former inspector in Her Majesty's Inspectorate of Schools. He talked about the system, how Scottish children's residential establishments were organised and who provided them over the latter part of the Review period. No one spoke to me about the earlier part.

14. I had contact with the Education Minister by correspondence when requesting a change in my remit to permit contact with individual survivors. I met his successor when I requested an extension of time to complete the Review.

15. I made requests for additional funds to commission research papers to support the work of the Review. I sought and obtained funds to employ a Plain English editor for the final draft of my report. These requests were dealt with constructively and expeditiously by Scottish Government officials.

Engagement with survivors during the Review

16. I had engagement with three organisations representing the interests of survivors: INCAS, FBGA and White Flowers Alba. I wanted to have contact with such organisations as well as survivors who were not meeting me in a representative capacity. In the case of survivor organisations, the challenge I faced was that they were very divided about the way they should proceed and what they should be seeking.

17. Around September/October 2005 I met Frank Docherty and Jim Kane who were representing INCAS. Jim Kane was an immensely sincere man with the best interests of others who had been in children's residential establishments at heart. Frank Docherty was the same. It was clear that they understood I was not conducting an inquiry or investigation or offering a forum at which individual survivors could recount their particular experiences. My feeling was they hoped that the Scottish Government might do more than commission a review.

18. I also met the Chairman of INCAS as part of the process of information gathering. He gave me an overview of what INCAS was doing and how it was organised. I got a sense from him that within the organisation different positions and directions were being taken by the members.

19. I first met Chris Daly and Helen Holland later in the process. Helen wanted to ensure there was opportunity for acknowledgement and, if appropriate, recompense for all those who were elderly or in poor health.

20. Some survivors had aspirations for a public inquiry. I think Helen Holland perceived my work as having leverage for a public inquiry. Chris Daly was focused on securing an inquiry. Some survivors saw the Review as a delaying tactic. Some were dismissive of the Review because it was not an inquiry. FBGA wanted an inquiry and saw the Review very much as second best. That said, all survivors I had contact with appeared to accept that the work I was doing was being done in the best interests of all survivors. I was grateful for their willingness to help facilitate what I was doing.

Engagement with other organisations

21. I sought co-operation and information from other parties. The response was mixed. Generally, there was defensiveness and a concern about what organisations might inadvertently let themselves in for if there was too much openness. That was the case even though we reassured them we were not carrying out an investigation or inquiry that involved an element of accountability. Some said they were unable to comment because of ongoing litigation. Lawyers had advised them what they could say to us and that was to say as little as possible.

Inspectorates

22. The Inspectorates responded positively and readily to my request for assistance and information. Their assistance in putting me in contact with retired inspectors was invaluable.

Local authorities

23. Some local authorities, because of the effects of two periods of local authority re-organisation, said they were willing to help but were unable to do so because they did not have the information that I was seeking.

24. I got a lukewarm or cool reception from others. They questioned, 'Why are we having a review at all?'. In their opinion the Review would not be telling them anything new. From previous inquiries and reviews they felt they had learned all the lessons and questioned what more the Review could find out or learn.

25. The Association of Directors of Social Work (ADSW) wrote to the Education Minister complaining about the fact that the Review had been commissioned and questioning the necessity for such a review. We arranged a meeting to explain to ADSW the nature of what we were doing, why we were doing it and how their co-operation might enable us to fulfil the remit. But it became a very different kind of meeting.

26. At the meeting a representative from the City of Edinburgh Council was very negative and opposed to all that we said. We tried to reassure those present that the Review was not an investigation or inquiry. We were seeking to establish what local authorities had by way of records, where they were and where we could get information about policy and practice.

Church of Scotland

27. In early 2006, I contacted the Church of Scotland. I received an open, positive response. The Church of Scotland offered to co-operate in any way that it could. I had a constructive meeting with the person responsible for oversight of the children's residential establishments that the Church provided.

The Catholic Church

28. I had difficulty in finding out who to communicate with on behalf of the Catholic providers.

29. In 2006, I met the Secretary of the Bishops Conference. I learned that children's residential establishments were provided through religious orders. I appreciated that the Bishops Conference could not compel individual Orders to co-operate with the Review. I had no power to compel organisations to engage with the Review.

30. Some Catholic providers were wholly co-operative and very open about what they knew and did not know about the nature and state of their records. By and large, they responded by telling us that they were uncertain about the scope and extent of the records they held but were willing to let us access their archives. Not many had systematic archiving or a record-keeping policy. In one establishment, records were in cardboard boxes in a basement in no particular order. There was nothing to protect the confidentiality of the contents. It became clear that many did not understand their responsibilities in relation to individual personal records.

31. The Order of Christian Brothers, headquartered in Cork, never replied to my enquiries.

Records

32. The Review found that many local authorities and other providers did not know what records existed, where records were located and what they contained. The Review also found that knowledge about systems of monitoring and inspection had been lost when people left organisations.

33. We found that a vast amount of records still existed. Records were scattered across organisations, archives, and even countries. Some were in the process of being examined. Some sat in boxes with little or no hint of what they contained. Some were in off-site secure storage.

34. We also found that records had been lost or destroyed. Potentially important information about practice was lost when practice changed. When new guidance was issued, previous guidance was destroyed. This was done, we were told, to avoid the risk of confusion. This meant we could not find evidence of what the previous policy and practice had been. Such losses could have been avoided had appropriate retention schedules been in place. Historically, organisations appear not to have recognised that records were a valuable resource.

35. We found there was a lack of central government records about residential childcare, such as records giving details of which organisations provided which services, at what locations and over what period of time. In central government records that did exist, there was evidence of inspections of individual establishments. We saw evidence of inspectors having asked to see records kept by establishments. Amongst other things, Inspectors were looking for evidence of action taken in response to the findings of the previous inspection.

36. The findings of the Review pointed to an urgent need to take action to preserve historical records so that former residents could have better prospects of getting access to their records and information about the residential schools and children's homes in which they lived as children.

37. Where possible, during the Review we turned to people who had worked for organisations to find out about past provision and practice. One man had written a book about his experience as an inspector. He was approaching 100 years of age when we met him. He had a remarkably clear memory and gave us valuable insight into policy and practice in the past.

38. Some organisations had good records. For example, Barnardo's had individual records for all the children they had cared for throughout the period we were concerned with. The records were archived in a way that made them

easily accessible and identifiable. Records of all kinds were well organised and there was an archivist who was able to highlight files that might be of assistance to us in carrying out our work.

39. We recognised that Barnardo's was, and is, a large organisation. It would have had greater resources than many much smaller organisations, enabling it to maintain a good record-keeping system and employ an archivist.

Access by former residents to records

40. When survivors asked to access records held by local authorities, they were not allowed to do so without a social work official being present. That made many reluctant to view the records because they did not want somebody else seeing what had been written about them. They would have preferred to go into a room with their file and read it alone.

41. In reading their files, some former residents learned about circumstances in their past life, before being in in a residential care setting, of which they had been unaware. That was both a surprise and, in some cases, a shock to them. Others were disappointed to find no record of incidents they remembered, such as when they were punished. Some thought records were selective. We tried to reassure them. We said records may have been made but not filed due to clerical error. Some were concerned there were no records of medical inspections, visitors or events they took part in such as concerts.

Quarriers records – concerns of survivors

42. The person in charge of the Quarriers archive, Josie Bell, had previously been a member of staff in Quarriers. Some former residents remembered her, and

felt that an independent archivist should have been appointed. When we visited Quarriers, we found the archivist very helpful. She pointed us to records we might be interested in, such as minutes of the meetings of the Board of Quarriers and annual reports. The annual reports were a fascinating insight into Quarriers over the years. They were largely celebratory in the way school annual reports are.

Focus of the review

43. The focus of the Review was on the systems of laws, rules and regulations that governed residential schools and children's homes and on how those establishments complied with these. To do this we sought records and other documentary evidence that would inform our understanding of the extent to which the laws, rules and regulations were respected. That process drew our attention to organisations' record-keeping and what they had done in terms of preserving records and making them accessible. Historically, record-keeping seemed to be seen as a necessary, but unwelcome, chore. Once a record was made, the file was put away and the record, it would seem, was not seen as having any further relevance or usefulness.

44. I was critical of record-keeping in my Report. Organisations thought that I had expected them to keep everything. That was not the case. I was expecting them to have kept records which showed they complied with the laws, rules and regulations and used such records as a resource in the improvement of provision and practice. Historically, the notion of records as a resource was not generally evident.

The Review's Advisory Group

45. In mid-2006, I set up an Advisory Group. The group included a representative of the Catholic Church. Another member had been a senior health professional and had a very good knowledge of organisational systems. There was a representative of the National Archives of Scotland and a former

member of the Education Department inspectorate. Professor Andy Kendrick was also a member. I took advice from the Advisory Group on proposals I had for dealing with particular issues and on how to respond to any difficulties which cropped up.

Research

46. As part of the Review I commissioned two reviews: a literature review, undertaken by Professor Kendrick, looking at the incidence of abuse in children's residential establishments across the period spanned by my Review and a review by Susan Elsley of societal attitudes to children and social policy changes in the period 1950 to 1995.

Findings

47. Research material about children's lives in Scotland and the experiences of those in residential establishments was scarce. Attitudes to children had changed over time as had attitudes to punishment and how to respond to complaints.

48. I had regard to what the law specified could be done in respect of the use of corporal punishment. There was repeated evidence, through the testimony of individuals and some documentary evidence, of legal limitations not being adhered to.

49. As regards emotional or psychological abuse, the legal and regulatory provisions did not adequately protect children from such abuse. We heard accounts of inappropriate responses from adults to children, such as denigration, humiliation and excessively harsh verbal responses which demeaned and belittled them.

50. Particularly during the early part of the review period, some people employed to work in the residential childcare sector were probably unsuitable. By that I

mean people were employed who did not possess the range of skills to deal with children in an appropriate way. Often people were employed because they were available and willing to work for a very poor wage. In some establishments, residents were retained when they were due to leave and given work to do. In their new role, they followed practices they had experienced as children in their residential settings. There was no legal requirement to employ staff with residential childcare qualifications. There were poor standards of staff recruitment, training and oversight, coupled with the negative effect on recruitment of low pay. The low pay issue continued across the period spanned by the Review.

51. Children were isolated from their families and in some, perhaps many, children's residential establishments those in charge appeared to have a dismissive attitude to parents and other family members. Parents, often it seemed, were not taken any more seriously than the children.

52. Children generally did not talk about their abuse. If they did they were not believed. We heard of children being told, 'You are making it up, 'don't you be telling lies, go away and play'. Some former residents recalled that when a member of staff was spoken to by a manager following a complaint, nothing changed. It seemed that a lot happened that was not recorded, not followed up, and not acted upon.

53. Given the remit of the Review, and the information we gathered in the course of our work, it would not be appropriate to attempt an assessment of how well the system treated children in general in residential establishments. We came across evidence of good or acceptable practice and of poor and unacceptable practice. Some children experienced very good care and spoke of it being better than the care they would have received had they been at home. Very few said that everything and everyone was bad all the time.

Recommendations of the Review

54. I was not asked in the remit to make recommendations. However, given the findings of the Review, I considered it necessary to make certain recommendations.

55. The recommendations can be found in Chapter 7 of the Review report. They were grouped into three broad categories and focused on (a) current provision to ensure the welfare and safety of looked after and accommodated children, (b) former residents' needs and (c) records.

56. I recommended more should be done about access to records and there should be a review of the public records legislation. I also recommended the setting up of a National Task Group to review regularly services for looked after children. I had in mind an independent public body having the capacity to challenge government and hold government to account for what it said it was going to do.

57. I could not find any extant record of what was done in response to the recommendations of previous reviews and inquiries over the years. To some extent the same recommendations came up time and time again. That was a concern for me. I felt there needed to be a means of monitoring action in response to the Review's recommendations and progress towards fully implementing them. I saw a National Task Group as a way of doing that.

Response to the Review

58. The Scottish Government responded very positively to many of the things I recommended. It issued a press release on the day my report was published welcoming my findings. Survivors came to the press conference at which I presented the Review's findings. Their response was very positive. They welcomed my report, endorsed my findings, supported my recommendations, and hoped that the Review would be a basis for progress towards their ultimate goal – a public inquiry.

Did the Review answer Chris Daly's question – "Why was this allowed to happen to me?"

59. The Review was not an investigation of particular experiences of abuse. For individual survivors it could not answer the question, 'Why was this allowed to happen to me?' But the Review identified a number of factors which may have given rise to circumstances in which children in residential establishments could be abused. Many of those factors were systemic failings.

60. First, there was a failure to follow consistently the safeguards in the legal provisions applying to children in residential establishments. If asked, 'Had each establishment done everything required by law, would that have prevented abuse?', my answer would be 'No'. Perpetrators of abuse can be clever, devious and sometimes stupid. Had legal requirements been adhered to consistently, I am convinced there would have been less physical abuse. The law regarding corporal punishment during the Review period was clear and very specific.

61. Second, the Review concluded that there was a failure to listen, and give adequate weight to children's complaints and concerns about their treatment. Children were often told 'You are lying, you made it up' or 'Run along it didn't mean anything, it wasn't any harm to you'. That kind of dismissal was common. Insufficient attention was paid to what children were saying.

62. Third, during most of the period covered by the Review, there was public acceptance, even endorsement, of corporal punishment. While corporal punishment may have been common in wider society, that did not make it acceptable to ignore the limits specified for the use of corporal punishment in children's residential establishments. In the Review, and later in TTBH, we heard frequently about former residents experiencing excessive physical punishment.

63. Fourth, during the period covered by the Review there were no agreed national standards of care for children in residential establishments. Some efforts were made to improve standards of professional knowledge and conduct but there had never been an explicit set of standards.

64. Fifth, there was inconsistent, and at times insufficient, monitoring and inspection of children's residential establishments. Different people whose job it was to inspect and monitor looked for different things and were not necessarily informed by the same set of standards or expectations. Also, at times, there was insufficient monitoring. A range of people had responsibilities in residential children's establishments that could be regarded as monitoring. I am not sure that they recognised that their responsibilities involved monitoring.

65. Sixth, boards and members of the local authority councils had a visitation responsibility in some cases. All the records we found, and we did not find many, seemed to suggest those were regarded as VIP visits. Those in charge of children's residential establishments knew in advance of such visits. Efforts were made to have everything in good shape for the visitors. That was not unworthy but such visits would not have enabled actual monitoring.

66. Seventh, there was ineffective management in some residential establishments at the level of the person in overall charge. We looked for evidence of managers putting on record advice on improving practice that had been given to individuals, such as house parents, following a complaint. We looked for, but could not find, anything which indicated that the manager had exercised his or her functions correctly in dealing with a complaint.

67. Eighth, there were poor standards of staff recruitment, staff training and oversight, coupled with the negative effects on recruitment of low pay for care staff.

68. Ninth, especially in the earlier part of the Review period, members of the public, including some parents of children in residential establishments, were reluctant to question or challenge the decisions and responses of those in charge of such establishments, particularly voluntary establishments, in relation to complaints about standards of care and the wellbeing of the children.

69. Tenth, some of those in charge of children's residential establishments adopted a superior, even dismissive, attitude towards parents and other family members of children in the care of such establishments.

Time To Be Heard

Background

70. A conference was held on 25 November 2008 entitled "Historic Abuse Systemic Review - One Year On".

71. Around that time the Scottish Government announced there would be a consultation on an acknowledgement and accountability forum. In September 2009, the Scottish Government decided to pilot a confidential forum which, subsequently, was called "Time To Be Heard". There was unbridled anger amongst many survivors at the decision to exclude an accountability function from the pilot.

72. The decision to test the Pilot Forum using only former Quarriers residents was largely settled before I became involved with its development and implementation. One factor which influenced that decision was the perceived

difficulty in getting institutions to co-operate and participate in a pilot if they had not been subject to prosecutions. Another was the fact that Quarriers had good records and that was seen as a way of facilitating the Pilot Forum in contacting people. I wrote a letter addressed to everyone who had contacted Quarriers in the previous five years seeking their records, inviting them to apply to take part in the Pilot Forum.

Meetings in February and March 2010

73. I was asked to take part in two public meetings in February and March 2010. One was for professionals in the residential childcare system and one for former residents of children's homes and residential establishments. The purpose of the meetings was to present the rationale for taking TTBH forward on a pilot basis using a single care provider and to explain the TTBH process.

74. By that stage, the Scottish Human Rights Commission (SHRC) had advised the Scottish Government that it was unhappy about a pilot forum being launched before completion of its report. The SHRC had been asked to develop a human rights framework for an acknowledgement and accountability forum. Before its work was completed, Scottish Ministers decided against an acknowledgement and accountability forum and opted instead for a confidential acknowledgement forum. They did so without consulting the SHRC.

75. Professor Alan Miller of the SHRC came to both meetings. At each meeting, he spoke on behalf of the SHRC. He argued that what we were doing would be helpful and could be relevant to the wider delivery of the human rights framework that the SHRC was proposing. He was very helpful at both meetings.

76. The meeting for the providers was, relatively speaking, dispassionate, unemotional, and broadly accepting of the pilot forum initiative. From memory, the issue of the change from what had been promised (an acknowledgment and accountability forum) to what was being delivered (a confidential forum for survivors) did not feature very largely in the discussions at this meeting.

77. The meeting with survivors was an angry meeting. Some survivors were unhappy with the decisions that had been taken. The reason for their anger was that the Pilot Forum was losing the element of accountability they had been expecting it to have. There would be no opportunity to hold individuals and institutions to account. They were also very angry about the choice of a single institution (Quarriers) for the Pilot Forum. Those who had been resident in children's homes other than Quarriers, argued they were getting nothing as they could not participate in the pilot. There was also real concern that so many of those who were old and infirm were not getting a chance to participate in the pilot.

78. As the meeting went on, people began to respond to repeated angry interventions from the floor. One woman stood up and said she hadn't been involved in any meetings of this kind before. She said 'I can see the value of what is on offer. I don't want this meeting to be informed only by the views of those people who have spoken before now. I want my views to be reflected. I don't like being here in an atmosphere of this kind. I find this meeting hurtful and I totally respect the best intentions of what is on offer'. The atmosphere in the meeting changed following her intervention.

Pilot forum advisory group

79. Before TTBH began, I set up an advisory group. Helen Holland was a member of that group. She acted in a wholly professional manner. On 30 August 2010, she and Chris Daly submitted a petition to the Public Petitions Committee of the Scottish Parliament for "Time For All To Be Heard". Helen Holland was driven to do so by a sense of outrage at the fact that TTBH was restricted to

one institution and that former residents in other institutions, particularly those who were ageing and/or ill, did not have access to TTBH.

Some comments and observations

80. During TTBH, many people said they experienced abuse while in care. What struck me was that we heard this from people who did not know each other, and from people who did not know who else was coming to talk to us or what period they would be talking to us about. We were hearing repeatedly about the same types of abuse and the same abusive practices. I saw this as a form of co-incidental corroboration of the individual accounts. We heard from a wide range of people including people holding senior positions in society and people who were making a first disclosure. Many of these were people who were not pursuing a claim for compensation nor wanting to support others making such a claim. None were people who were simply repeating what they had read in the newspapers. I and the other commissioners felt that the people who came to us were being honest and that many, for whatever reason, felt the need after many years to unburden themselves of their experiences as children in residential care.

81. Many participants in TTBH told us about abusive experiences while in the care of Quarriers. We were also told about cottages where practices were considered to be good and in which children had very happy times. There were cottages in which people had mixed experiences. Those taking part in TTBH said management were aware of these disparities but did nothing to change things.

The Restorative Justice pilot

82. The development of a Restorative Justice Toolkit took place at the same time as the development of the Pilot Forum. The papers that TTBH gave to each participant included information on the Restorative Justice Toolkit. If they were interested, they were given contact details they could follow up, but TTBH was

not promoting or driving this. The Restorative Justice Toolkit had been developed in parallel with TTBH and was a matter between SACRO and Quarriers. I did not have direct involvement with the Restorative Justice pilot.

Closing thoughts

83. My overall conclusion was that there were many good people within the system who were doing good things. The problem was that there were many instances of either neglect or disregard of the legal obligations or rejection or ignorance of what would have been the right way to respond to children's needs. There was a considerable element of trust within society that childcare establishments would look after children properly and keep them safe and that did not always happen.

84. Children are in a special position if they are in the care of the state. During the Review period, standards of care had to be considered against what was understood to be in the best interests of the welfare of children. That might mean differences in practice and treatment in comparison to what was happening outwith children's residential care settings. The law applying to children in care differed at times from popular opinion and societal norms. That was something I felt people needed to be aware of.

85. You cannot necessarily compare the experiences of a child in the community with a child in residential care because they are not subject to the same legal protections. For example, we did not require, and still do not require, parents to maintain a punishment book. During the review period, the law required that a record of any punishment should be kept when a vulnerable child was in the care of the state. The assumption was that a residential childcare establishment would be a place of safety. The law expected a child to be safe and protected when in State care. A domestic home could have been, or might not have been, a safe place.

86. People working in children's residential establishments needed a clear and regularly updated distillation of the key childcare principles and legal obligations that should have informed their work. Realistically, in their day-to-day practice, they were often unable to draw on detailed advice and guidance.

87. The disappointment and anger of survivors who were precluded from participation in TTBH by the choice of a single institution for the pilot forum was understandable. Their discontent with the Scottish Government's strategy related to the fact that many of them were ageing and in poor health. They argued their hopes of getting closure through acknowledgement were at serious risk because of the passage of time.

88. The decision to exclude an accountability dimension from the pilot forum added dramatically to their lack of confidence in the Scottish Government's action programme for survivors.

89. The Scottish Government's strategy to act sequentially, rather than concurrently, in addressing survivors' needs was deeply regretted, even resented, by survivors with whom I met. That approach added to the distress and sense of neglect that so many expressed.

90. Survivors' pressure for government action to address their needs was, in my experience, driven at least as much, if not more, by a profound sense of injustice and the need to be believed rather than by pressure for redress, however much they were entitled to that.

91. TTBH, despite its limitations, demonstrated unequivocally the value of a confidential forum. That it did so in the midst of such profound disappointment at the decision to exclude an accountability function from its remit is all the more significant in validating the need to be heard and believed.

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

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

Dated 1st July 2020 .....