

Friday, 17 October 2025

(9.30 am)

LADY SMITH: Good morning, and welcome to the last day of this phase, Phase 9 in our case study hearings.

As most people, if not everybody here, will know, what's going to happen today is that closing submissions are going to be presented from the various providers of residential care for children who fell within what we've categorised as healthcare additional support and disability needs.

Now, those of you who have been here during the section in which we were hearing evidence about children who were deaf or had impaired hearing will know that, in that section, we had the assistance of, dare I say -- may I say, excellent interpretation, and sometimes there have been people in the public gallery who have found that very helpful. And so we have today, again, made provision for interpreters to be in the public gallery for anybody who may wish to take advantage of that. So, when the closing submissions are presented, they will be interpreted in British Sign Language for anyone who's attending who is deaf or hearing impaired and would find that helpful.

In the usual way, it's possible that there may be pauses in the interpretation to allow for the

1 interpretation to happen but, I have to say, my
2 experience has been our interpreters cope remarkably
3 well and we've not noticed any interruption in the
4 interpretation at all.

5 Also, if anybody in the public gallery would find it
6 helpful to access the services of an interpreter to
7 speak to a member of the Inquiry team, I hope they'll
8 feel free to do so, because that interpretation service
9 is there to be available for that as well.

10 Very well, I'm going to turn now to the submissions
11 and invite Ms Innes to address me.

12 Ms Innes.

13 Closing submissions by Ms Innes

14 MS INNES: Thank you, my Lady.

15 Since the hearings in this case study commenced on
16 29 April of this year, we've had 43 days of evidence in
17 relation to 17 institutions, including long-stay
18 hospitals, residential special schools and schools for
19 deaf and visually impaired children. The providers
20 include the NHS, a local authority, religious orders,
21 charitable organisations, whether trusts or companies,
22 as well as independent companies.

23 The evidence of 133 people has been heard during
24 this case study, including evidence which has been read
25 in. Nearly 11,500 documents recovered by the Inquiry

1 are relevant to this case study, with approximately
2 1,500 of these having been identified and included in
3 the bundle for the hearings for particular scrutiny.

4 For the first time, the Inquiry has led evidence
5 from deaf witnesses, using British Sign Language with
6 the assistance of interpreters and a deaf intermediary.

7 Sadly, the Inquiry has heard evidence that children
8 with disabilities, additional support needs or long-term
9 healthcare needs were abused over the period under
10 consideration. There was also serious emotional abuse
11 and neglect. Some children and young people were not
12 even afforded dignity or humanity. Some of that was
13 vividly depicted in documentaries from the time which
14 were shown during hearings, as well as in archival
15 records. We heard of humiliating practices, such as
16 shaming children or discussing their private information
17 at group meetings with peers and staff.

18 There was also evidence of poor accommodation,
19 lacking in privacy and personal space, and sometimes
20 even basics such as being clean, warm and safe, which is
21 demonstrative of the view of the children taken by those
22 in charge of those institutions.

23 Over the course of the evidence, a number of themes
24 emerged, some of which are common to previous case
25 studies, but can be viewed from a new perspective in

1 this context. As I said in my opening submissions,
2 given the vulnerability of the children and young people
3 concerned, the importance of this cannot be understated.

4 So what was the purpose of their placement in these
5 institutions? Surprisingly, with such specialist
6 settings, the answer was often unclear, both in terms of
7 admission and any plan for their stay. Often, children
8 and young people appeared to be placed for the purposes
9 of containment or control of what was viewed as
10 challenging behaviour for which they were to blame.
11 Historically, we heard that children were characterised
12 as untrainable or uneducable and described as
13 'maladjusted', all terms redolent of how these
14 vulnerable children and young people were perceived.

15 The regimes to which they were then subjected
16 reflected that view. We heard examples of corporal
17 punishment being deployed, contrary to government
18 guidance, policy and legislation. The imposition of
19 sanctions on out-of-school time for in-school behaviour
20 demonstrated that there was no escape from the closed
21 culture which pervaded some of these institutions.

22 In settings targeted at the provision of education
23 for deaf children, for part of the period, we heard that
24 the use of sign language or gesture was physically
25 punished. As a result, some children were unable to

1 access the education which was being provided and their
2 attempts to communicate were stifled.

3 Turning to some of the broader themes emerging from
4 the evidence.

5 Evidence was heard in relation to failures to listen
6 to children or, as I've said, allow them to communicate
7 effectively to enable them to report abuse.

8 We also heard evidence from parents who struggled to
9 have their voices heard.

10 LADY SMITH: And indeed, parents who were regarded as not
11 worthy of being listened to.

12 MS INNES: That's correct, my Lady.

13 Complaint systems were lacking, but even when
14 complaints were made, some children found that they were
15 disbelieved. We heard evidence of more than one person,
16 later convicted of abuse, who was able to move amongst
17 institutions even when there had been complaints of
18 abuse in a particular place of work.

19 There were failures to properly implement child
20 protection policies, for example not following up on
21 reports of child protection matters and not collating or
22 triangulating relevant information. In some, there was
23 a complete absence of policy, even at a time when such
24 procedures were being widely implemented.

25 In some cases, there was inadequate staffing to

1 properly supervise children. There were examples of
2 lacking criminal record checks and sloppy recruitment
3 practices. Particularly where institutions had to adapt
4 to survive, there was either inadequate training or
5 staff lacking in the appropriate skills, attitudes and
6 values to care for children with different needs.

7 We also heard evidence of divides between care and
8 education staff or nursing and medical staff. This
9 included failures to share appropriate information, and
10 that did not have children at the heart.

11 More broadly, the expert evidence noted that the
12 legislative and policy framework in this area is very
13 complex. In relation to agencies; health, social work,
14 education and other services can be involved. This
15 underlines the need for true multidisciplinary working,
16 but also highlights the difficulty that an individual
17 practitioner can face in ensuring that a child does not
18 fall through the cracks.

19 Evidence was heard of poor supervision and lack of
20 provision of appropriate sex education, allowing
21 sexually abusive behaviours to flourish. In addition,
22 sexual behaviour was sometimes dismissed as
23 experimenting or horseplay. Bullying was rife, with
24 children mirroring abusive behaviour by staff.
25 'Chaotic' was a word used to describe more than one of

1 the institutions considered.

2 Restraint was a theme in this case study, as in
3 others; however, we heard that it disproportionately
4 affects children with additional support needs. We
5 heard evidence in the early period of the use of
6 straitjackets or sleeves. We also heard that, in the
7 early period, there was no training as to its use. But
8 we heard evidence that even the introduction of training
9 in relation to restraint brought risks, as staff would
10 then see it as a first, rather than a last, resort.
11 Isolation was also a common reaction to challenging
12 behaviour.

13 We have heard more current examples of inappropriate
14 restraint being deployed, resulting in disciplinary
15 action, and we know that it continues to be an area of
16 particular concern.

17 Chemical restraint or sedation was also used. The
18 routine administration of drugs prescribed as required
19 to children and young people with learning difficulties
20 was another means of exerting control without care for
21 the individual.

22 LADY SMITH: But it made life easier for the staff.

23 MS INNES: That's correct, and we heard in -- obviously I'm
24 thinking there particularly of long-stay hospitals, and
25 we heard there were issues with staffing, for example,

1 very few staff with large wards of children.

2 Turning to issues of governance.

3 Given the patchwork of different providers,
4 a variety of governance issues emerged. In some, there
5 was a complete lack of governance, i.e. no board, no
6 accountability. In others, boards were too remote to
7 provide proper oversight. In still others, there was
8 a lack of relevant skills or understanding of the role
9 of the board. The basis upon which some boards were
10 constituted was historical and did not allow for
11 sufficient turnover or selection of members with
12 appropriate experience, albeit we've heard evidence that
13 steps were taken to amend that over time.

14 LADY SMITH: Yes. That's a real risk, I think, that's come
15 through across the board, to use a pun -- and not just
16 in this phase, but elsewhere I have seen it happening --
17 old systems of people being long, long serving. That's
18 not a criticism of them as individuals, but there's no
19 refreshing of the board occurring, not sufficient
20 identification of what matrix of experience you need
21 amongst your board members, which is very much required,
22 particularly with this cohort of children here.

23 MS INNES: Indeed, my Lady, and we also see in relation to
24 issues of leadership, which I'll come on to in a moment,
25 that sometimes the board's focus was on a particular

1 challenge that they were facing at the time, so, for
2 example, a financial issue, and people were recruited on
3 to the board to focus perhaps on those issues, and
4 almost forgetting that the welfare of children was at
5 the heart of the organisation's purpose.

6 LADY SMITH: Yes.

7 MS INNES: In terms of leadership, the Inquiry heard
8 evidence about leadership which was autocratic, with too
9 much power being concentrated in the hands of one
10 individual. It has also heard about dysfunctional
11 management teams in which the dysfunction became the
12 focus, rather than the care of children.

13 It has also heard about the danger of leaders having
14 their eye off the ball when their attention is turned to
15 a particular project, such as the provision of a new
16 building, rather than the core of the organisation's
17 work. So it affects the board, the governance body, but
18 it also affects leadership within the institution.

19 Turning to inspection.

20 There were examples of failures to engage with
21 inspectors or outside scrutiny, even when it had become
22 legally required. There were long gaps between
23 inspections and confusion about responsibility, for
24 example in relation to hospital schools.

25 It is clear that the advent of the local authority

1 inspection service in the 1990s -- a precursor to the
2 Care Commission and Care Inspectorate -- challenged many
3 practices and procedures. However, there remained
4 concerns about the ability of inspections to detect
5 serious issues, such as, for example, those at
6 Donaldson's, which only came to light with the
7 appointment of a new principal, despite a high level of
8 ongoing inspection activity prior to her appointment.

9 As I said in opening submissions, the Inquiry was
10 aware of the BBC Disclosure programme in relation to
11 Skye House, aired in February of this year, which,
12 whilst postdating 2014, raised issues relevant to the
13 Inquiry's terms of reference.

14 As well as hearing and ingathering evidence from
15 health boards, we've also had evidence from the Mental
16 Welfare Commission, together with Healthcare Improvement
17 Scotland, who have been commissioned by Scottish
18 Government to carry out a series of visits to all child
19 and adolescent inpatient units, and we heard last week
20 that that work's ongoing.

21 LADY SMITH: Yes.

22 MS INNES: We've also heard evidence from the quality
23 assurance network run by the Royal College of
24 Psychiatrists, QNIC.

25 It is notable that the Mental Welfare Commission

1 emphasised its role as a watchdog, not as an inspector
2 or regulator, and Healthcare Improvement Scotland
3 contrasted its powers in relation to independent
4 healthcare providers as opposed to its powers in
5 relation to the NHS. This may indicate a gap which
6 needs to be filled.

7 A lack of proper and consistent data-gathering was
8 identified by expert evidence as a risk for the
9 development of appropriate legislation and policy. As
10 a result, children and young people with additional
11 support needs, disabilities and long-term healthcare
12 needs risk being invisible, and that, of course, sets
13 a context in which abuse can occur.

14 Unfortunately, the fact that time has passed and
15 systems have developed does not mean to say that abuse
16 no longer occurs. The Inquiry heard evidence last week
17 of the Hesley Review in England, published in 2022 and
18 2023, in which a number of the same systemic failings
19 were identified as those which I have outlined from the
20 evidence from the hearings that we've had.

21 This underlines the need for constant vigilance and
22 care on the part of all those with responsibility for
23 the most vulnerable children and young people to ensure
24 that the experience of applicants is not repeated.

25 LADY SMITH: Thank you very much, Ms Innes.

1 MS INNES: Thank you, my Lady.

2 LADY SMITH: I'd now like to turn to the representation for
3 INCAS, Ms McCall. I'd invite you to address me next,
4 please.

5 Closing submissions by Ms McCall

6 MS MCCALL: Thank you, my Lady.

7 At the close of this case study, as Counsel to the
8 Inquiry has just done, INCAS emphasises again the
9 particular vulnerability of the children who found
10 themselves accommodated in the various settings about
11 which the Inquiry has been hearing.

12 These were children who needed additional support,
13 who had healthcare issues or disabilities. For some of
14 them, communication was difficult; for others, they were
15 considered troubled or problematic. But those factors
16 do not excuse the reality that, once again, the Inquiry
17 has heard that children often had nowhere to turn when
18 something happened to them. Where they did raise
19 an issue, it was rare for them to be believed and for
20 something to be done.

21 As one psychologist put it: children were not
22 listened to or taken seriously in many areas of their
23 lives, so if you report and you're not believed, or
24 nothing happens, then what's the point?

25 Another witness noted the absence of a robust

1 investigation of allegations, even those made by
2 parents. He noted those parents weren't considered
3 worthy of making an allegation against care staff, and
4 this meant that, from the offset, there was no belief
5 that anything could have happened to the children in
6 their care.

7 The problem was not only that children were unable
8 or unwilling to report; the Inquiry has heard of
9 institutions having their own culture which could
10 inhibit the reporting of abuse out of fear of
11 consequences or the reality that nothing would be done.
12 On some occasions when staff members did report physical
13 abuse by other staff, they were shunned by their
14 colleagues.

15 LADY SMITH: Yes.

16 MS MCCALL: In relation to findings of abuse, the Inquiry
17 has heard from many survivors who have described abuse
18 of various kinds taking place in different institutions.
19 The accounts of physical and sexual abuse are shocking.
20 The Inquiry has also heard from a number of former staff
21 members who deny being the perpetrators of that abuse.

22 INCAS has no doubt that your Ladyship will carefully
23 consider the evidence of survivors, and that she will
24 bear in mind that there is, in many instances, support
25 for a survivor's account, for example in the form of

1 similar fact testimony from another survivor, or in the
2 form of contemporaneous records.

3 In assessing the credibility of denials of abuse,
4 INCAS asks your Ladyship to bear in mind that experience
5 tells us that perpetrators will deny being abusers, even
6 in the face of having been convicted to the criminal
7 standard, and this case study is replete with examples
8 of such denials.

9 INCAS does not intend to invite specific findings in
10 relation to individuals; it's anticipated your Ladyship
11 will make such findings as she considers appropriate.
12 The convictions of numerous perpetrators stand as
13 a historical record, vindicating survivors in their
14 accounts. Rather, this submission addresses the common
15 systemic themes that have come to light, and any
16 references to specific evidence are intended to be
17 illustrative of the wider picture.

18 I turn then to staff recruitment and training.

19 The Inquiry heard from a number of former staff
20 members about the process of their recruitment. While
21 they may have been trained, for example, as teachers,
22 staff were sometimes then engaged in a care-centred role
23 as houseparents or overnight carers. Often they did not
24 receive additional training to undertake that role or
25 staff were employed as houseparents without any relevant

1 qualifications and without then getting any proper
2 training.

3 There was also evidence of resistance to training by
4 those in charge. Janie McManus described a report by
5 Her Majesty's Inspector that the headteacher of
6 Donaldson's was hostile to staff being trained by child
7 protection officers from the local authority.

8 LADY SMITH: Yes.

9 MS MCCALL: In terms of education of children, following on
10 from the lack of proper recruitment processes and
11 qualification of staff, the Inquiry has heard evidence
12 about the lack of education taking place in some of the
13 institutions. Howard Mitchell described the regime at
14 Lennox Castle as being about preventing challenging
15 behaviour, rather than trying to fulfil anyone's
16 potential. There can be little doubt that no priority
17 was given to educating children in any of the settings
18 under investigation.

19 LADY SMITH: And thinking particularly, I suppose, of the
20 evidence about Lennox Castle, is INCAS's position that
21 the lack of education was so woeful that it got to the
22 stage that it is a form of abuse to take children into
23 an institution where they're supposed to be provided
24 with ongoing education and it doesn't happen?

25 MS MCCALL: Yes, my Lady, particularly the length of time

1 children were there exacerbates that problem.

2 LADY SMITH: Yes. And no effort being made to, as I think

3 was recognised in the evidence at one point, address the

4 issue by making arrangements for the children to go out

5 of the residential institution to somewhere that would

6 educate them.

7 MS MCCALL: Correct, my Lady.

8 LADY SMITH: They just were left to muddle along with not

9 much school happening at all.

10 MS MCCALL: Yes.

11 LADY SMITH: Yes.

12 MS MCCALL: My Lady, turning to inappropriate punishments.

13 The Inquiry has heard a lot of evidence of

14 inappropriate punishment being meted out to children.

15 Going back to Lennox Castle, slapping of patients was

16 described as 'endemic'. Children on one of the wards

17 would be routinely smacked.

18 At some schools, corporal punishment was used

19 contrary to Scottish Education Department principles.

20 At other institutions, corporal punishment was used

21 without a proper policy in place and without records

22 being kept. Isolation was used to discipline children,

23 along with them being locked in their rooms or even

24 being locked in cupboards. This was a pattern repeated

25 across many different institutions and locations. Other

1 forms of physical violence were described: children
2 having their arms twisted up their backs, being hit on
3 the knuckles with implements.

4 A number of other inappropriate forms of punishment
5 were spoken about by witnesses, for example having their
6 shoes and jackets taken away in the winter; being
7 humiliated or being made to do a walk of shame for
8 wetting the bed; being denied visits and having meals
9 withheld; being smacked on a bare bottom.

10 Some punishments were particularly cruel in their
11 context. Deaf children were punished for using sign
12 language with their peers. While it's accepted that
13 historically it was believed that deaf children should
14 learn to communicate without sign language, punishment
15 for using it should be considered abusive. It hampered
16 children's communication with their peers and will
17 likely have impacted on their ability to form meaningful
18 friendships. In addition, it will have deprived
19 children of a means by which they may have felt more
20 comfortable to disclose what was happening to them.

21 My Lady, the Inquiry will wish to consider whether
22 there was a culture of impunity. There were a number of
23 examples of abuse having been reported, established to
24 have occurred and yet without consequences. For
25 example, at Harmeny, a member of staff physically

1 assaulted a child, admitted to it, but was allowed to
2 stay in post with no report being made to any outside
3 agency. Thereafter, that staff member went on to commit
4 further offences.

5 At Lennox Castle, Howard Mitchell noted that staff
6 often did not officially report things that were wrong
7 and illegal because they felt there was no point.

8 The culture of impunity was not confined to abuse by
9 staff members. Samantha Smith gave evidence that she
10 reported an incident of sexual abuse of a young man.
11 The perpetrator, another patient, denied it. The
12 perpetrator was moved to a different ward but, within
13 weeks, was moved back to the ward where the victim
14 lived. Mr Mitchell reported the sexual abuse of a young
15 disabled patient by another older patient, but nothing
16 was done.

17 A culture of impunity does not protect survivors.
18 As has been seen in some instances, the result of that
19 failure was to create yet more victims.

20 Turning to the use of medication.

21 A disturbing aspect of the evidence in this case
22 study is the use of medication to control children.
23 Rather than being for a therapeutic purpose, the Inquiry
24 has heard a multiplicity of examples of children being
25 given sedatives and anti-psychotics in order to manage

1 their behaviour. That evidence came from both staff and
2 children. It appears that the medication was in fact
3 prescribed by medical practitioners.

4 Leaving aside whether there were proper clinical
5 reasons for prescribing such medication to individual
6 children, the evidence suggests that its use was
7 inappropriate and abusive.

8 Moving to restraint, my Lady.

9 Similar to previous case studies, the Inquiry has
10 heard evidence of the extensive use of restraint. In
11 a number of instances, there appears to have been a lack
12 of training or improper training as to how to safely
13 restrain a child, and a lack of proper procedures to
14 guide staff as to when restraint should or should not be
15 used.

16 There were examples of forms of restraint which went
17 beyond safe holding, including the tying of limbs. Such
18 practices were abusive. The scale of the use of
19 restraint indicates organisational cultures in which
20 staff were incapable of supporting children and finding
21 other ways to de-escalate situations.

22 In relation to inspection and oversight, the Inquiry
23 has heard troubling evidence of resistance to
24 inspection. For example, at Donaldson's, it was
25 reported that the headteacher was extremely resistant to

1 the school being inspected by the Education Department.
2 This was in the context of detailed allegations of abuse
3 at the school, including the rape of a girl and pupils
4 being kicked by staff.

5 In the mid-1990s, a report in respect of
6 Lennox Castle by the Scottish Health Advisory Service
7 was apparently toned down to spare the blushes of the
8 local NHS trust. The report referred to residents'
9 unhappiness at being restrained by sedation and
10 confinement to bed, but originally it had also described
11 patients having their arms twisted behind their backs,
12 the use of cold showers and the removal of shoes as
13 punishments.

14 While it's noted that the Head of Donaldson's was
15 later suspended, what these and other examples reveal is
16 an issue in relation to investigating allegations where
17 there may have been no immediate corroboration and the
18 evidence was circumstantial. The impression is that the
19 responsible authorities found these types of situations
20 challenging.

21 There seems historically to have been a willingness
22 to simply dismiss an uncorroborated allegation as
23 unfounded, rather than to treat it as possible and
24 investigate more thoroughly.

25 A number of local authority witnesses have

1 acknowledged in their evidence that their legacy
2 institutions failed in their obligations to protect
3 children from abuse. Other organisations have
4 acknowledged abuse in their opening statements, and
5 INCAS thanks them for their candour and their apologies.

6 In conclusion, in 1975, when he took up post as
7 a nursing assistant at Lennox Castle, Howard Mitchell
8 described himself as shocked by the conditions he
9 encountered. Over 20 years later, the commissioner,
10 Samantha Smith, also described herself as shocked by the
11 institution.

12 The brutality of the environments in which many
13 children found themselves persisted over decades. One
14 institution was described as a 'system of containment'.
15 A former resident of Ladyfield spoke of 'not living,
16 just existing'.

17 The picture presented in this case study, across all
18 the institutions investigated, is one of children being
19 stripped of their dignity, of being routinely
20 humiliated, living in environments where casual violence
21 was endemic, where they were not protected from abusive
22 staff or from abuse by their peers. They had no
23 opportunity to flourish and fulfil their potential; they
24 were not thought to have any potential.

25 While he was talking specifically about

1 Lennox Castle, the words of Howard Mitchell may be apt
2 to describe the experience of children in all the
3 institutions in this case study. He said:

4 'People who lived there were victims. They were
5 victims of a terrible period of institutional and care
6 history. They were abused by the system and they were
7 abused as individuals. That's obvious for anybody with
8 any care, compassion and insight to see.'

9 I'm obliged, my Lady.

10 LADY SMITH: Thank you very much, Ms McCall.

11 I would now like to turn to representation for
12 Scottish NHS health boards, and we looked at, of course,
13 in the course of the evidence, provision by NHS
14 Greater Glasgow and Clyde, Forth Valley and Dumfries and
15 Galloway.

16 That takes me to Mr Davidson, please.

17 Closing submissions by Mr Davidson

18 MR DAVIDSON: I'd like to start my speech with
19 an acknowledgment of abuse and an apology on behalf of
20 the five Scottish NHS health boards that I represent.

21 The Inquiry has the health boards' full written
22 closing submission, a document with 17 pages and
23 76 paragraphs, which I'll refer to as the full NHS
24 closing submission. But, in line with the approach
25 I adopted at the start of this phase, I don't intend to

1 read out every single word of that lengthy document;
2 rather, given the constraints of time, I intend to carry
3 out some careful editing so that this speech can be
4 concluded within the allocated timeframe. Although I am
5 attempting to abbreviate the full NHS closing
6 submission, I trust that I will not omit anything of
7 significance.

8 For the avoidance of doubt, the full NHS closing
9 submission constitutes the final and formal position of
10 the relevant NHS health boards with regards to Phase 9.

11 LADY SMITH: And can I interject just to thank you for that
12 full submission, Mr Davidson. It's plain that a lot of
13 work has gone into it and there's been significant
14 contribution from all of the boards, of course two whom
15 I didn't mention earlier, there are five in total. So
16 thank you for that.

17 MR DAVIDSON: No, I'm obliged.

18 So, starting with paragraph 2 of the full NHS
19 closing submission, it is acknowledged that abuse took
20 place within each of the NHS institutions under
21 examination. When I delivered the opening submission
22 some months ago, I made it clear that the health boards
23 acknowledged this abuse. As was also made clear in the
24 NHS opening submission, the various health boards
25 offered, and again the five health boards offer it

1 today, an apology to the children and young people who
2 experienced abuse in these NHS institutions, and I'll
3 call those people the NHS survivors. The boards are
4 deeply and sincerely sorry.

5 So, moving on to paragraph 6 of the full NHS closing
6 submission, I want to say something about the worldwide
7 reputation of the whole National Health Service since
8 its foundation in 1948.

9 When looking at the last seven decades, it has been
10 said by some informed and independent observers, and
11 happily it is still said by some observers, that our NHS
12 is the envy of the world. In many, and one would hope
13 most respects, that remains as true today as it has ever
14 been. Despite the harrowing evidence that has been
15 adduced about some NHS hospitals during Phase 9, it
16 would be fair to point out that the Inquiry has also
17 heard evidence about at least some examples of the
18 excellence of our NHS in action during the material
19 period.

20 Sadly, however, it is now clear that not all those
21 children and young people in NHS facilities experienced
22 what could, on any view, be described as acceptable. As
23 I said in the opening statement, one abused child is one
24 too many.

25 With regards to the evidence adduced from the

1 applicants who resided in NHS hospitals during the
2 relevant period, it is believed that the sharing of
3 their experiences during Phase 9 can and will bring
4 positive change. As Counsel to the Inquiry rightly
5 noted in her opening statement, the closure of these NHS
6 institutions is only part of the picture. Closure of
7 some hospitals in Scotland does not necessarily mean
8 that abuse of children in healthcare or other specialist
9 settings is a thing of the past, or that we cannot learn
10 from what happened.

11 The same point can be put in a different way: when
12 dealing with the care of vulnerable children and young
13 adults in the modern world, there can and should be no
14 room for complacency in modern Scotland.

15 So, key themes. I turn then to paragraph 8 of the
16 full NHS closing submission. It's headed 'Key themes'.
17 These are the key themes that we have identified at the
18 close of this phase. Under reference to those various
19 headings, we have indicated that we provide the
20 following submissions.

21 So, developing insight by the health boards. The
22 first topic is the developing insight of the health
23 boards. This is dealt with at paragraphs 9 to 12 of the
24 full NHS closing submission.

25 At the outset of this phase, the Inquiry heard from

1 three senior figures. These individuals represented
2 Greater Glasgow Health Board, Dumfries and Galloway and
3 Forth Valley. It would be fair to say that, in the
4 course of their sworn testimony, all three senior
5 figures expanded upon the Section 21 Responses prepared
6 for the Inquiry by their respective health boards. When
7 set against the terms of their health boards' Section 21
8 Response, each one of them provided a more comprehensive
9 acknowledgment of, and apology for, the abuse which had
10 taken place in the relevant NHS institution.

11 It is submitted that the approach of these three
12 senior figures was not just responsible, it was entirely
13 proper and necessary. Their approach reflected and
14 reflects a growing appreciation on the part of the
15 various health boards of the full extent of the abuse
16 which took place in the various NHS institutions during
17 the relevant period.

18 The three senior figures also recognised the
19 achievement of this Inquiry. In particular, all three
20 of them acknowledged the important work of this Inquiry
21 in bringing the accounts of the NHS survivors out of the
22 shadows. This further acknowledgment of the past is
23 informed by the powerful and moving evidence of the
24 extremely courageous and dignified NHS survivors who
25 have spoken up to this Inquiry.

1 This testimony of the NHS survivors, whether it was
2 delivered directly or adduced in some other way, has
3 brought home to the modern management of the health
4 boards the full horror of what some children were forced
5 to endure.

6 The impact of the evidence given by the NHS
7 survivors should be seen in its proper perspective. The
8 NHS survivors endured abuse while they were under the
9 care of the institutions as vulnerable children. The
10 NHS survivors were, for obvious and self-evident
11 reasons, in need of care and nurturing. Rather than
12 receiving the support that they needed and deserved, the
13 NHS survivors were subjected to abuse and neglect. The
14 enormity of that betrayal cannot be exaggerated.

15 Turning to institutions as a place of containment,
16 referred to as 'warehousing' during at least some of the
17 evidence. I want to look on to this second theme,
18 an examination of the NHS institutions as places of
19 containment. The issue is considered fully in
20 paragraphs 13 and 14 of the full NHS closing submission.

21 On a number of occasions, the Inquiry heard
22 a description of the relevant NHS institutions as places
23 of control or containment for the disabled and for those
24 with additional support needs. Indeed, this was
25 a recurring theme across all the healthcare institutions

1 examined in this phase of the Inquiry's work.

2 About 20 years ago, a decision was taken to close
3 three NHS hospitals, and I refer to Lennox Castle, the
4 Royal Scottish National Hospital and the Crichton.
5 Those three hospitals have been the subject of
6 particular scrutiny in Phase 9.

7 In the years prior to 2005, healthcare professionals
8 had been struggling to discern whether there was any
9 healthcare need in taking many of these children into
10 a residential healthcare environment.

11 LADY SMITH: I'm glad you raised that, Mr Davidson, because
12 it did seem, in the case of some of the children, they
13 ended up in one of these environments on the basis that
14 there didn't seem to be anywhere else to put them,
15 although it was recognised that they needed help.

16 MR DAVIDSON: Exactly. Exactly.

17 LADY SMITH: And the families needed help.

18 MR DAVIDSON: Indeed.

19 And almost to reinforce the point, the approaches
20 taken in these various institutions generally appear to
21 have been an approach based on containment, rather than,
22 as Peter Doran put it in his oral evidence to the
23 Inquiry --

24 LADY SMITH: Yes.

25 MR DAVIDSON: -- places where there was a horticultural,

1 i.e. growth, model of care.

2 Although they may not have used the same terminology
3 as Mr Doran, it is clear that the decision-makers in the
4 early years of this century were fully aware of the need
5 to allow/encourage growth in what Mr Doran might
6 describe as a walled garden or a greenhouse, rather than
7 a warehouse. At least to some extent, that awareness of
8 the decision-makers underpinned the enlightened decision
9 to close down long-term residential facilities for
10 children and young adults.

11 The move away from institutionalisation. The third
12 key theme explored in the full NHS closing submission is
13 the ultimate move away from the old-fashioned model of
14 institutionalisation. This issue is considered within
15 paragraphs 15 and 16 of the full NHS closing submission.

16 There was an apparent move away from
17 institutionalisation in the early 2000s. The Inquiry
18 has heard much about this gradual, albeit slow, process
19 by which these NHS institutions were brought to a close.
20 The relevant institutions were closed in recognition of
21 the view that care in the community was a better way of
22 allowing such children to flourish and to reach their
23 true potential.

24 By about 2005, the containment model had died. It
25 died for good reason and, in this regard, the health

1 boards salute the excellent research into this now
2 historical process that has been carried out by
3 Professor Franklin and Dr Greenaway of the Manchester
4 Metropolitan University.

5 With the benefit of hindsight, it is clear that the
6 move to de-institutionalisation has profited the
7 additional support needs community immensely. The
8 potential advantages of this move did not, apparently
9 for a variety of reasons, begin to be appreciated by
10 those in positions of authority until about the 1990s.
11 The slow rate of change is a matter of considerable
12 regret to each of the boards.

13 Abuse taking many forms. The fourth key theme
14 identified within the full NHS closing submission is
15 that of abuse taking many forms. This is covered at
16 paragraph 17. In short, the boards salute the excellent
17 work of Professor Franklin and Dr Greenaway. These two
18 individuals attended Mint House on the final day of
19 evidence. During their sworn testimony, they helpfully
20 acknowledged that abuse can take many forms. That
21 insight was certainly something that emerged in the
22 evidence of most, if not all, of the NHS survivors. The
23 health boards acknowledge the importance and relevance
24 of this analysis.

25 Physical and sexual abuse. I must now turn to make

1 a submission about physical and sexual abuse. This
2 issue is considered more fully within paragraphs 18 to
3 20 of the full NHS final submission.

4 A number of the NHS survivors detailed abuse of this
5 kind and, for the avoidance of doubt, I am talking here
6 about criminal offences. Apart from repeating
7 an apology already tendered in the opening section of my
8 speech, there is very little, if anything, that can be
9 said by me today in relation to that harrowing evidence.

10 All I can do on behalf of my instructing health
11 boards is confirm that the boards unequivocally condemn
12 and abhor any abuse of that nature. For that kind of
13 conduct, there can be no defence. Given the
14 vulnerability of the NHS survivors and the special
15 circumstances within which they came to be placed in the
16 relevant NHS facilities, I am not even going to attempt
17 to make a plea in mitigation.

18 It is recognised that the physical pain, both
19 immediate and enduring, from such criminal activity was
20 appalling. But worse for many was the emotional and
21 psychological scarring produced by such assaults. This
22 evidently caused long-term damage and provoked, in many
23 survivors, a range of emotions. For example, some NHS
24 survivors developed an enduring and entirely
25 understandable resentment of authority. For others,

1 their self-esteem was destroyed. Some developed
2 an inability to trust others that has stayed with them
3 for many decades. And finally, some survivors also gave
4 evidence to the effect that they considered that they
5 themselves then required to behave in the same way just
6 to get by.

7 The use of physical restraint. I now want to move
8 on to look at a different theme; that is the use of
9 physical restraint. This is a matter which is dealt
10 with at paragraphs 21 to 24 of the full NHS closing
11 submission.

12 The use of physical restraint was a common feature
13 of the evidence regarding the various healthcare
14 institutions. The Inquiry has heard significant
15 evidence from the NHS survivors about restraint
16 practices which appear to have been both unnecessary and
17 abusive. In some instances, inappropriate restraint
18 appears to have been commonplace.

19 To modern eyes, the culture of some NHS institutions
20 could reasonably be described as more than just
21 concerning. In particular, children who were exhibiting
22 challenging behaviour -- and I use the term 'challenging
23 behaviour' with some hesitation for a reason which I'll
24 make clear in a later part of my speech, those children
25 were simply restrained and/or labelled as 'problematic'.

1 With regards to children falling within that
2 category, it is a matter of regret that no attempt was
3 made to understand their unique and complex needs.

4 So at the outset, within this chapter, it is
5 relevant to highlight two important points. The first
6 is that restraint is a practice which retains its place
7 in certain defined contexts, even in modern-day
8 healthcare. The boards refer particularly to the report
9 of Professor Franklin and others, which is before the
10 Inquiry, as well as to the witness evidence of several
11 clinicians who gave evidence. It is the board's
12 position that there will always be a requirement for
13 health boards to have procedures in place which are
14 utilised if a child or young person places themselves or
15 others at physical risk of harm.

16 When looking at the issue of restraint, the second
17 point to highlight is that health boards were, and
18 perhaps still are, in a unique position. Well, why do
19 I say that? Well, the answer is not entirely
20 straightforward. I recognise, my Lady, that this is
21 sensitive territory, and although I must tread
22 carefully, I submit that a fair answer to my question
23 must necessarily involve an analysis of the status and
24 the particular objectives of a medical facility.
25 I emphasise the word 'medical facility' as distinct

1 from, say, an orphanage or a List D school or, indeed,
2 an independent boarding school.

3 When looking at the past and ongoing use of
4 restraint in NHS facilities, it is reasonable to
5 acknowledge that restraint may -- I repeat: may -- in
6 some cases be clinically indicated for a therapeutic
7 benefit, for example to control a patient's distress or
8 to prevent harm to themselves or to others. In modern
9 practice, it is rightly regarded as a last resort, but
10 it still has a place in modern healthcare.

11 Despite my submission that restraint can still be
12 used as a last resort, I must still face up to the
13 serious allegations made by the NHS survivors about this
14 aspect of their experience as patients. Their accounts
15 of excessive and arbitrary physical restraint, or of
16 physical restraint being used as a form of punishment,
17 are accepted as reliable and abhorred and condemned by
18 me and the boards.

19 It is clear that restraint must have some clinical
20 benefit, and it must be carried out as a last resort and
21 in accordance with the law, where other de-escalation
22 techniques have failed. As Professor Franklin indicated
23 in her oral evidence, the problem with restraint is in
24 its overuse. There is plainly an issue where it is used
25 as a matter of routine, with people not necessarily

1 realising that a child's behaviour is trying to indicate
2 distress.

3 As your Ladyship observed on at least one occasion,
4 the so-called 'challenging behaviour' does not
5 necessarily indicate that a child is trying to challenge
6 the adult. The health boards respectfully accept the
7 wisdom of that judicial view.

8 The next chapter is the use of sedation. Similar
9 considerations as already outlined above apply
10 mutatis mutandis to the use of sedation, otherwise
11 referred to as chemical restraint, and this topic is
12 covered at paragraphs 25 to 27 of the full NHS closing
13 submission.

14 In this context, it is again acknowledged by the
15 health boards that it is now apparent that at least some
16 degree of sedation was commonplace in hospitals to
17 control the inconvenient manifestation of patients'
18 distress, rather than to control the distress itself,
19 and that is not just regrettable.

20 Substandard provision of education. The next key
21 theme identified is the substandard provision of
22 education. In the full NHS closing submission, the
23 issue is covered in some detail, with particular
24 reference to the individual institutions, at
25 paragraphs 28 to 33.

1 Whilst the evidence tended to indicate something of
2 a mixed picture, it is worth trying to draw together the
3 relevant themes into a single submission.

4 The evidence indicated that there was a poor or
5 substandard provision of education across the various
6 NHS institutions during the relevant period. Throughout
7 the years when the relevant establishments were
8 operational, children of school age in Scotland were
9 entitled to an education. It is therefore inexcusable
10 that the relevant NHS establishments failed to meet
11 their duties and obligations to some children in that
12 regard.

13 Staffing, lack of oversight and governance. The
14 next key theme is that of staffing, lack of oversight
15 and governance. This is dealt with in paragraphs 34 to
16 40 of the full NHS closing submission.

17 Staffing in particular appeared to be an issue at
18 various times across the various institutions considered
19 in this phase. It is particularly concerning that there
20 were, at various times, very low staff-to-patient
21 ratios, and even reports from medical staff that they
22 were scarcely able to maintain minimum standards of
23 medical care. In addition, a lack of oversight and
24 governance at various times meant that, across the NHS
25 institutions and within the institutions themselves,

1 approaches to patient reviews and the discipline of
2 staff were at best variable, and at worst virtually
3 absent.

4 Your Ladyship may recall particularly the evidence
5 of Dr Murray to the effect that, when viewed by modern
6 eyes, such structures were redolent of a very unhealthy
7 leadership culture. In this speech, I do not intend to
8 depart from that view, but I propose to add one thing.

9 And this, my Lady, is slightly different from the
10 formal full final submission; this is added for the
11 speech.

12 LADY SMITH: Thank you.

13 MR DAVIDSON: On a number of occasions, the Inquiry has
14 heard evidence about the importance of leadership. At
15 the risk of stating the obvious, it would be difficult
16 to overestimate the value of having people of the
17 highest quality and highest integrity at the helm of any
18 modern healthcare provider, including, for example,
19 today's NHS in Scotland.

20 Having heard evidence from various very senior
21 figures within the modern NHS of Scotland, your Ladyship
22 has had an opportunity to assess the calibre of at least
23 some of those who are running the NHS in Scotland today.
24 What opinion did your Ladyship form?

25 Of course, it could be said that an assessment of

1 a witness giving evidence in a formal inquiry does not
2 provide the best way of evaluating his or her qualities
3 and weaknesses as a leader. To some extent, I must
4 accept the validity of that argument. But, nonetheless,
5 I want to say something more about this potentially
6 important issue.

7 Having considered their sworn testimony, it is
8 submitted that your Ladyship can have confidence in the
9 high quality of the leaders of the modern Scottish NHS.
10 Although it would be artificial to pretend that nobody
11 could ever carry out abuse in a modern NHS facility, the
12 health boards want to reassure your Ladyship and the
13 public that modern practices within and outwith the NHS
14 mean that there are reliable procedures in place to
15 identify abuse quickly and prevent it. Modern practice
16 in an NHS facility can be checked by independent
17 monitoring and, more precisely, independent watchdogs.
18 The quality of those non-NHS bodies is important, but
19 good leadership at the top of the NHS must also
20 necessarily be part of an approach to the provision of
21 a high-quality health service.

22 My Lady, I am returning now to the written
23 submission.

24 LADY SMITH: Thank you.

25 MR DAVIDSON: The next heading in the full NHS closing

1 submission is 'Evidence as to what was happening in the
2 adult estate'.

3 The penultimate theme is that there was much
4 evidence about what was happening at various times in
5 the so-called 'adult estate'. This is covered at
6 paragraphs 41 and 42 of the full NHS final submission.

7 The Inquiry heard evidence from a number of
8 witnesses, particularly Samantha Smith, John Dalrymple,
9 Rhona Morrison, Gillian Anderson and Frances Brown, who
10 were able to speak to what was happening on the adult
11 wards of the various NHS institutions, but not the
12 children's wards.

13 The boards respectfully submit that whilst the
14 evidence of these witnesses -- and I am referring to
15 Samantha Smith et al -- was undoubtedly illuminating and
16 of value in providing a degree of insight into the
17 general culture of these various institutions during
18 their twilight years, there is a basis for treading
19 carefully. It is respectfully submitted that
20 the Inquiry ought to adopt a degree of caution in
21 relation to any findings of abuse or abusive practices
22 in relation to children based solely upon the evidence
23 of those named witnesses.

24 It would, it is respectfully submitted, be wrong to
25 rely upon what was happening on the adult wards and then

1 go on to infer that something of the same kind was
2 necessarily happening on the children's wards at the
3 material time. Indeed, Howard Mitchell, who had
4 experience of both children's wards and adults' wards,
5 he confirmed that at least some of the divergences in
6 practice existed with regards to how children were cared
7 for at Lennox Castle as distinct from adult patients.

8 That is not, however, in any way to play down the
9 importance of the evidence of these named witnesses.
10 When informing their approach to Phase 9, evidence of
11 this kind has greatly assisted the health boards, and,
12 it is hoped, your Ladyship as well, in understanding the
13 culture within these institutions, a culture that had
14 implications for the care of adults and children.

15 So, finally, the need for children to have a voice.

16 Now, one key theme identified by the boards is the
17 need for children to have a voice. This is dealt with
18 more fully in paragraphs 43 and 44 of the full NHS final
19 submission.

20 It was tolerably clear that many NHS survivors felt
21 they could not speak up about what was happening to them
22 for a variety of reasons, often perceived power
23 imbalance. However, it may also have been the case that
24 many did not possess and were not furnished with the
25 necessary communications to do so. This was perhaps

1 a unique feature of the children to whom this phase
2 relates, something that was acknowledged by INCAS in
3 their opening statement, and it was also touched upon by
4 several of the witnesses.

5 In this context, your Ladyship has also observed
6 that a witness in a different phase of the Inquiry had
7 been asked why he or she had not complained about abuse.
8 When asked this question, the relevant witness had
9 replied that he or she did not have the lexicon to allow
10 him or her to articulate what was perceived to be wrong.
11 Under reference to that reply, the health boards accept
12 that many of the children who resided in NHS facilities
13 during the relevant period didn't have the lexicon to
14 pass on or press complaints.

15 When considering the availability of raising and
16 progressing complaints, Gillian Anderson gave helpful
17 evidence. Ms Anderson observed, inter alia, that there
18 are particular challenges facing vulnerable children.
19 Such children may often be unable to communicate even
20 the most basic allegations to someone in authority.
21 Another witness, Samantha Smith, observed that even
22 people with profound and complex disabilities can
23 communicate, but only if someone listens carefully
24 enough. It is recognised that the Inquiry has provided
25 many of those affected with a forum to do exactly that.

1 The present and the future. I turn at this point to
2 the present and the future, and I am at paragraphs 45 to
3 47 of the full NHS closing submission.

4 As has been stressed, long-term residential
5 hospitals for the relevant group -- I am talking here
6 about children, young people with mental health needs,
7 neurodivergence or learning disability -- no longer
8 exist in Scotland. Therefore, in the most basic sense,
9 the Inquiry can be reassured that such environments no
10 longer offer care to the relevant group; indeed,
11 environments of that kind have not been operational in
12 Scotland for nearly a quarter of a century. However,
13 there is much work that has been done by the various
14 health boards who have participated in this Inquiry to
15 seek to reduce the risk of abuse to child patients
16 within their care, at the moment and in the future, to
17 the lowest level practicable.

18 Practices which were commonplace in the wider
19 British society at the time can now be recognised as
20 wholly inappropriate, particularly in relation to
21 methods utilised in order to attempt to manage children
22 and young people exhibiting challenging behaviours. As
23 I mention below, the boards' approaches to caring for
24 and nurturing children have developed, thankfully,
25 significantly.

1 The boards do not seek to excuse or to minimise the
2 abusive conduct that occurred within the various NHS
3 institutions under scrutiny. Although these
4 institutions closed their doors many years ago, the
5 full, final submission of the NHS must go on to consider
6 what lessons have been learned and how robust modern
7 practices actually are.

8 Within the full NHS final submission, the health
9 boards have sought to highlight the fact that the
10 current regimes in force throughout the modern NHS are
11 unrecognisable when compared with the regimes that were
12 in force during the second half of the 20th century.
13 The boards' respective current approaches, which have
14 been their approaches now for a number of years, seek to
15 place the nurture of children at the centre of staff
16 training and policy. To echo a theme explored by me in
17 an earlier part of this speech, a desire to have regard
18 for horticulture is one way of advancing the need to
19 nurture and nourish. Warehousing vulnerable children
20 and young adults has rightly been consigned to history.

21 The measures now in place on behalf of
22 Greater Glasgow are set out in some greater detail at
23 paragraphs 48 to 53 of the full, final submission; those
24 of Dumfries and Galloway can be found at paragraphs 54
25 to 58; those of Forth Valley are set out in

1 paragraphs 59 to 61; those of Fife Health Board can be
2 found at paragraph 62 and 63; and, finally, Grampian
3 Health Board's measures are detailed at paragraphs 64 to
4 69 of the full NHS final submission. Unfortunately, the
5 constraints of time and the fact that five separate
6 health boards are represented by me are such that it is
7 not possible to go into any great detail about these
8 individual measures which do vary slightly from board to
9 board.

10 LADY SMITH: I see the details are set out in the full,
11 final submission. That's very helpful, Mr Davidson,
12 thank you.

13 MR DAVIDSON: I am obliged. They are incorporated -- as we
14 say in the law, brevitatibus causa. However, the devil
15 may be in the detail and your Ladyship has all of that
16 in those paragraphs.

17 LADY SMITH: Yes.

18 MR DAVIDSON: Turning now to anger, guilt and shame.

19 Before concluding, it must be recognised that anger
20 guilt and shame are three emotions which have been
21 prominent throughout the testimony of survivors who have
22 been heard in this phase of the Inquiry.

23 Survivors are rightly angry at the health boards.
24 The boards hear that anger. Insofar as this is
25 possible, the boards share that anger. More

1 particularly, the health boards abhor and condemn the
2 individuals who perpetuated the abuse that we have heard
3 of, or tolerated it, or allowed it to happen.

4 Guilt and shame are understandable emotions but,
5 with great respect, misplaced in the survivors. Theirs
6 is not the guilt or the shame. Some individual
7 employees of the health boards of the past let down
8 a number of children in their care. The boards now need
9 to make absolutely certain that their employees do not
10 do so again. To that end, the boards all remain
11 committed to taking account of what can be learned from
12 this process in this Inquiry.

13 Conclusion and thanks. The boards wish to thank the
14 Inquiry for the time, effort and attention paid to the
15 various healthcare institutions in uncovering features
16 of the past that could not have been done so effectively
17 in any other way.

18 In its vast work with the past healthcare
19 institutions and all other kinds of residential care,
20 it -- and I mean 'it' is the Inquiry -- is undoubtedly
21 making a huge contribution to the protection and welfare
22 of children in Scotland and beyond.

23 I wish to thank the Inquiry team for their
24 helpfulness, courtesy and professionalism throughout
25 this whole process. I also wish to thank the Inquiry

1 staff who have helped me, my learned junior and my
2 professional colleagues at the CLO with unfailing
3 courtesy and skill during the hearing.

4 Finally, and above all, the boards wish to thank and
5 pay tribute to all the survivors who have helped the
6 Inquiry with its work. They have had tremendous courage
7 to come forward and speak about their most painful and
8 intimate memories. The important work of the Inquiry
9 depended on them and the modern boards have learned so
10 much from what they have had to say. The NHS survivors
11 have the immense admiration and immense respect of the
12 five health boards.

13 LADY SMITH: Mr Davidson, thank you for that.

14 I'd now like to turn, please, to representation for
15 Fife Council and invite Ms Thomson to address me.

16 When you're ready, Ms Thomson.

17 Closing submissions by Ms Thomson

18 MS THOMSON: My Lady, Fife Council is grateful for the
19 opportunity to participate in the work of the Inquiry,
20 to listen and to learn. Fife Council wishes to take
21 this opportunity to acknowledge that some of the
22 children entrusted to its care during the period being
23 examined by the Inquiry were abused by some of those
24 responsible for their safety and wellbeing; to
25 acknowledge the long-term and devastating impact of

1 childhood abuse on survivors and their families; to
2 offer its sincere, unreserved and heartfelt apologies to
3 those it failed to protect; and to state its commitment
4 to making positive change for the future of all children
5 and young people in residential care.

6 Representatives of Fife Council and its legal team
7 have watched all relevant evidence during this phase.
8 Ken Gourlay, the Chief Executive of Fife Council, has
9 been kept up to date with the work of the Inquiry and is
10 here today, as is Maria Lloyd, Head of Education, from
11 whom your Ladyship heard during this phase.

12 Fife Council and its statutory predecessors was
13 responsible for three residential schools that
14 accommodated children with additional support needs:
15 Ovenstone Residential School, Melville House and
16 Linwood Hall. The schools provided residential care and
17 education for maladjusted children, who most likely had
18 experienced poverty and neglect, and who suffered from
19 emotional and behavioural difficulties.

20 The history of the schools is summarised at pages 2
21 to 4 of the council's longer written submission.
22 Melville House and Linwood Hall were opened in the
23 mid-1970s. Ovenstone had a longer history, but all
24 three schools closed in 1998, following a change of
25 policy to community-based residential care for children.

1 Fife Council Education Service has not provided
2 residential schools for children since 1998. Care and
3 education are now provided for separately by the local
4 authority.

5 Fife Council Social Work Service currently has nine
6 houses providing residential care for children and young
7 people with a variety of needs. The houses range from
8 a singleton placement to a maximum of four beds and, in
9 total, can accommodate up to 35 children and young
10 people.

11 My Lady, I propose to offer a submission in four
12 brief chapters: the organisational culture within Fife
13 Council in days gone by; the nature and extent of the
14 abuse that took place in the residential schools run by
15 the council; the failings that allowed that abuse to
16 take place; and lessons learned and changes made.

17 Organisational culture. For the reasons explained
18 at page 4 of the council's written submission, my focus
19 is on the organisational culture in the 1970s and 1980s.

20 LADY SMITH: Yes, thank you.

21 MS THOMSON: My Lady, Fife Council does not shirk from the
22 fact that the organisational culture at that time
23 created an environment in which abuse could thrive. All
24 three schools provided residential care and education
25 for maladjusted children. Children who behaved badly

1 were seen as bad children. Adults believed that
2 children had control over their behaviour and that bad
3 behaviour was a choice.

4 The aim of the residential schools was to correct
5 bad behaviour. Correcting bad behaviour was seen as the
6 measure of success. This led to the development of
7 practices intended to control bad behaviour; practices,
8 as your Ladyship has observed, that made life easier for
9 staff.

10 Punishment, humiliation and medication were used to
11 control bad behaviour. Strict corporal punishment gave
12 the impression that bad behaviour was being managed
13 successfully. Behaviours considered to be bad,
14 including bedwetting, were discussed in front of staff
15 and other children. Children were belittled, ridiculed
16 and humiliated. Valium was prescribed to manage
17 challenging behaviour. Fife Council recognises that
18 this practice was completely inappropriate.

19 Children were seen as having a low status because of
20 the very fact of being in care. They were there, after
21 all, because they had been in trouble or were troubled,
22 and so they were seen as less than truthful and
23 unreliable.

24 Then there was a culture of disbelief and an anxiety
25 amongst victims of abuse that if they disclosed what was

1 happening to them, they would not be believed.

2 Parents whose children had been taken into care were
3 perceived as failures. They were not listened to
4 either. As your Ladyship observed, they were not worthy
5 of being listened to. Class, and the way that society
6 viewed those who lived in poverty, were barriers to
7 making complaints.

8 These aspects of the organisational culture created
9 an environment in which abuse could thrive unchecked and
10 unchallenged. The culture was, perhaps, reflective of
11 prevailing societal attitudes at the time. Until at
12 least the 1970s, the very thought that a person in
13 a position of trust would abuse children was alien, both
14 to the general public and to professionals.

15 Turning to the nature and extent of abuse. Fife
16 Council accepts that abuse took place in all three
17 residential schools. The detail of particular
18 allegations that the council acknowledges are likely to
19 be true are set out in the Council's Section 21
20 Responses and summarised in its longer written
21 submission.

22 At Ovenstone School, Fife Council accepts and
23 acknowledges that Alexander Christie sexually abused
24 children, including both 'Jordan' and 'Peter'.

25 Corporal punishment, and in particular the slipper,

1 was used in response to the most trivial misdemeanours.
2 Children were threatened with the slipper to instil fear
3 and bring about compliance. The council also accepts
4 that children at Ovenstone were shaken violently and
5 force fed.

6 At Linwood Hall, Fife Council accepts and
7 acknowledges that, although the extent of his offending
8 is unclear from existing records, David Murphy sexually
9 abused children at Linwood Hall.

10 Further, there was a regime of fear and
11 intimidation, of harsh punishments which caused pain and
12 injury as well as humiliation, and which amounted to
13 emotional and physical abuse. There are examples at
14 page 8 of the council's written submission.

15 Children were encouraged to fight in order to
16 resolve disputes between them, and staff turned a blind
17 eye to peer-on-peer bullying and abuse.

18 Melville House. Fife Council accepts and
19 acknowledges that abuse took place at Melville House.
20 Between 1988 and 1997, there were a number of
21 investigations in response to allegations of abuse by
22 a sheriff, a solicitor, the Education Department and,
23 finally, a multidisciplinary steering group. Complaints
24 included slapping, being grabbed by the neck or throat
25 and excessive use of force in the course of restraint.

1 My Lady, the council extends its sincere thanks to
2 all those who gave evidence to the Inquiry about their
3 experience of abuse at its residential schools, and to
4 those who gave an account of the abuse they suffered in
5 written statements. The council commends their courage
6 and their strength. Their evidence was powerful and at
7 times harrowing. Those representatives of Fife Council
8 who listened to their evidence found that experience
9 very difficult and were deeply affected by it. They
10 want survivors of that abuse to know: your voices have
11 been heard. The council is committed to learning from
12 its mistakes. Your evidence has made a difference.
13 Today, children are listened to, heard and believed.

14 The culture within Ovenstone, Linwood Hall and
15 Melville House enabled abusers to act with impunity.
16 Fife Council is deeply ashamed of its past failure to
17 protect the children in its care, and, whilst no apology
18 can ever atone for that failure, the council hopes that
19 survivors can hear these words loudly and clearly: we
20 are deeply sorry.

21 Fife Council extends a sincere and unreserved
22 apology to all those who were abused whilst in its care.
23 The council would like to make clear, my Lady, that it
24 offers this acknowledgment and apology not because that
25 is what is expected of it, but because it has listened

1 to and heard the harrowing accounts of survivors of
2 abuse and is committed to ensuring that the mistakes of
3 the past are never repeated.

4 Fife Council also wishes to recognise and
5 acknowledge the substantial and lifelong harm caused by
6 abuse. The impacts described by survivors who gave
7 evidence during this phase include serious and long-term
8 mental health problems; difficulty with trust,
9 relationships and authority; crime and addiction; anger,
10 regret and low self-worth; difficulty maintaining
11 employment; a fear that because they were abused, they
12 might abuse their own children; and a missed opportunity
13 for happiness in adult life.

14 Black and Williams, in their report from 2002,
15 report survivors experiencing a misplaced sense of guilt
16 and responsibility. They say one common theme with the
17 survivors is the feeling of being responsible for
18 younger people being abused. They are not easily able
19 to acknowledge that at the time they were vulnerable
20 children themselves. A great deal of guilt was
21 expressed by some survivors, who feel that if they had
22 spoken out more clearly, then the abuse for many other
23 children would have stopped. They remember at the time
24 feeling responsible for what was done.

25 To those who carry with them this burden of guilt

1 and sense of responsibility, Fife Council would wish to
2 say this: it was not ever your fault. We failed to
3 listen to you. We failed to protect you. Because of
4 our failings, those who abused you were able to continue
5 their campaign of abuse and, for that, we are deeply
6 sorry.

7 LADY SMITH: Thank you.

8 MS THOMSON: Turning, my Lady, to my third chapter:
9 failings.

10 In 2001, David Murphy, a former housefather at
11 Linwood Hall was convicted of abusing children. His
12 appointment as housefather illustrates both the absence
13 of vetting procedures within the council at that time
14 and the devastating consequences of their absence.

15 Allegations of sexual abuse were first made against
16 Mr Murphy in the early 1970s, when he was employed at
17 St Margaret's Home. The allegations were reported to
18 the police, but there was no prosecution. The
19 allegations did result in Mr Murphy's suspension in
20 1973. However, he was later transferred to a role
21 working with elderly people, before applying for the
22 position of housefather at Linwood Hall in 1976.

23 Although the senior manager who had interviewed and
24 appointed Mr Murphy to that role was subsequently
25 advised of the earlier allegations and strong concerns

1 about his appointment were expressed, his offer of
2 employment was not withdrawn, nor was his contact with
3 children supervised. Mr Murphy went on to abuse
4 children at Linwood Hall.

5 This catastrophic failure of both vetting and
6 vigilance was compounded by the culture of disbelief and
7 poor understanding of child abuse at that time. So when
8 two children, who were then abused by Mr Murphy at
9 Linwood Hall attempted to disclose that abuse, one was
10 told it simply could not have happened and the other was
11 called a liar. No link was made to the warnings made at
12 the time of Mr Murphy's appointment.

13 Other systemic failures, my Lady, include a lack of
14 training, the absence of a formal complaints process or
15 whistleblowing policy, and inadequate record-keeping.
16 These systemic failures, against the background of the
17 organisational culture, meant that when children had the
18 courage to speak up and report abuse, their complaints
19 fell on deaf ears. They were not believed. Their
20 parents were not believed. Allegations were not
21 properly recorded or investigated. The person to whom
22 a complaint was made had a discretion as to whether it
23 would be listened to and acted upon or not. There was
24 no complaints process, allegations were dismissed --

25 LADY SMITH: Yes.

1 MS THOMSON: -- information relevant to child protection was
2 not shared.

3 So what of lessons learned and changes made? Black
4 and Williams made this observation in 2002:

5 'Countering the specific abuse which we now know was
6 happening in children's homes needs a combination of
7 personnel measures, increased commitment to listening to
8 children, monitoring of the quality of care and external
9 management systems. These should allow fears and
10 suspicions to be voiced for the benefit of children and
11 young people. Vigilance should be the watchword of all
12 who come into contact with children in care.'

13 There are echoes in that sentiment of what Counsel
14 to the Inquiry stressed in her submission, my Lady --

15 LADY SMITH: Yes.

16 MS THOMSON: -- the need for constant vigilance and care.

17 Well, times have changed, my Lady, and so has Fife
18 Council. Today, there is a greater knowledge and
19 understanding of child abuse, of the devastating impact
20 of abuse and of the need to protect children from abuse.
21 There have been changes to legislation, policy and
22 practice, and there has been a change in culture.

23 Children who displayed challenging behaviour were
24 once labelled as 'maladjusted' --

25 LADY SMITH: Yes.

1 MS THOMSON: -- children who behaved badly were once thought
2 of as 'bad children'. Today, it is understood that
3 behaviour is a means of communication and may be
4 a response to trauma. Once, punishment, humiliation and
5 medication were used to control bad behaviour. These
6 practices are utterly condemned by Fife Council.

7 There was once a culture of disbelief but today, my
8 Lady, children are listened to, heard and believed. As
9 Maria Lloyd said in her evidence, our starting point is
10 believing. Where an allegation is considered to be
11 credible, the member of staff is immediately suspended,
12 pending a full and thorough investigation.

13 LADY SMITH: And that is believing in the sense of accepting
14 that it is possible that what the child says happened
15 did happen.

16 MS THOMSON: Yes, my Lady.

17 LADY SMITH: And so following through a proper responsible
18 investigation on that basis?

19 MS THOMSON: Precisely so, my Lady, yes.

20 Whereas once parents were treated as second-class
21 citizens, today the council's model is one of
22 partnership, working with parents, whose voices are
23 heard and who are included in decision-making processes.

24 With regards to the systemic failures identified
25 earlier in my submission, the current position within

1 Fife Council is as follows, and there's further detail,
2 my Lady, at pages 17 to 21 of the council's written
3 submission.

4 Today, recruitment processes are robust and include
5 enhanced disclosure checks. This is important because,
6 as Black and Williams observed, trying to prevent
7 unsuitable people entering the caring professions,
8 remains the first line of protection for children and
9 young people.

10 All staff receive training in child protection,
11 trauma-informed practice and de-escalation. Whether or
12 not to investigate a complaint and how to go about that
13 task are no longer matters of discretion. There are
14 clearly established policies and processes that require
15 to be followed based on the Model Complaints Handling
16 Policy and Procedure, published by the Scottish Public
17 Services Ombudsman and adopted by the council.
18 Complaints must be recorded and thoroughly investigated.
19 There is a whistleblowing policy and staff are
20 encouraged to report concerns about misconduct and
21 unethical behaviour. There is external scrutiny from
22 various regulators. Records are now retained for
23 25 years.

24 Today, my Lady, when a child is taken into care,
25 there is a robust matching process and risk assessment

1 to understand the child's needs and ensure the staff
2 team has the capacity to meet their needs. The child's
3 voice is heard. Their views are taken into account in
4 determining what is in their best interests. All
5 residential care arrangements are reviewed on a monthly
6 basis by the chief social work officer. Children are
7 visited at least fortnightly and seen outwith their care
8 placement. Children in care have care plans, pathway
9 plans and exit interviews. A throughcare team provides
10 support beyond residential care. External managers
11 visit residential homes at least weekly to understand
12 the support needs of staff and to quality assure care
13 and compliance with standards. The council has
14 appointed a service manager for residential child care
15 to provide leadership and support and an escalation
16 policy has been developed to enable reviewing officers
17 to escalate concerns to senior leadership.

18 A multi-agency partnership approach to child
19 protection removes the professional hierarchy of long
20 ago and instead there is now a collaborative approach to
21 child protection, governance arrangements now include
22 the Child Protection Committee, Children in Fife and the
23 Corporate Parenting Board.

24 My Lady, Fife Council is not complacent. It has
25 identified a number of areas where further work is still

1 necessary. These are set out at pages 21 and 22 of the
2 council's written submission. These include improved
3 understanding of trauma, enhanced training on
4 de-escalation, with a view to reducing physical
5 interventions, offering greater support to children who
6 have disclosed abuse, further developing partnership
7 working to build relationships and trust, and the
8 development of a multi-agency complex case panel. In
9 addition, Fife Council is reflecting on how best to
10 create the conditions and training for staff to be
11 curious about colleagues' practice without being
12 suspicious.

13 There is, of course, a need for transparency and
14 sharing of all information relevant to child protection
15 but there is the conundrum of innocent until proven
16 guilty, that is to say having clarity as to what weight
17 should be given to unproven allegations when considering
18 recruitment of staff, suspension and termination of
19 employment. This is an area in which guidance in the
20 form of recommendations from the Inquiry would be very
21 welcome.

22 I repeat, my Lady, Fife Council is not complacent.
23 Whilst positive change has been made, the risk of abuse
24 can never be eradicated. Black and Williams' words
25 written in 2002 are equally valid today: vigilance

1 should be the watchword of all who come into contact
2 with children in care.

3 In conclusion, my Lady, Fife Council welcomes the
4 opportunity to learn that comes from a thorough and
5 independent scrutiny of the evidence, from listening to
6 and hearing the evidence with a willingness to learn,
7 from a commitment to avoid repeating past mistakes, from
8 the reflections of its own staff and, in due course,
9 from the Inquiry's findings and recommendations.

10 Should your Ladyship recommend that further changes
11 should be made to policies, practices or procedures in
12 order to safeguard the children and young people
13 entrusted to the council's care, those changes will be
14 made. Maria Lloyd, Head of Education, and James Ross,
15 Head of Social Work, are identified as points of contact
16 for the work stemming from this phase of the Inquiry.
17 They have already presented their lessons learned to the
18 Child Protection Committee and they stand ready to
19 follow up on all further recommendations and lessons
20 learned from this process.

21 Fife Council thanks the Inquiry for the opportunity
22 to participate in this phase of its work and will
23 continue to support the work of the Inquiry in future
24 phases.

25 Thank you, my Lady.

1 LADY SMITH: Ms Thomson, thank you very much for that.

2 Now, I am aware of the fact that we have been going
3 since 9.30 this morning. What I hope the stenographers
4 can cope with, and the interpreters can cope with, is if
5 I invite one further set of submissions, which I'm
6 guessing is not going to be particularly lengthy, from
7 Mr Rolfe for Daughters of Charity.

8 Is my guess right, Mr Rolfe?

9 MR ROLFE: I should hope so, my Lady.

10 LADY SMITH: Very well. Can I check with the stenographers,
11 is that okay?

12 Thank you.

13 Mr Rolfe, when you're ready. This is Daughters of
14 Charity, who, of course, were involved with the
15 provision of residential care at St Vincent's and St
16 Joseph's.

17 Mr Rolfe.

18 Closing Submissions by Mr Rolfe

19 MR ROLFE: I'm much obliged, my Lady.

20 The Daughters of Charity would like to thank your
21 Ladyship for the opportunity to make these closing
22 submissions.

23 Representatives of the Daughters of Charity were and
24 have been present during each part of this phase of the
25 Inquiry, when evidence was led from applicants who had

1 experience of establishments under their control at the
2 material times. That was the case for both live witness
3 evidence and evidence by way of read-ins of applicant
4 statements.

5 It was extremely important for the Daughters of
6 Charity that they bore witness to the accounts of
7 survivors. For the avoidance of any doubt, the
8 Daughters of Charity accept the accounts of each of
9 those applicants in full.

10 LADY SMITH: This is just one applicant -- of course, there
11 were others who were equally important -- but can I
12 check that does of course include an applicant with the
13 pseudonym 'Alan', who gave evidence about how children
14 had to do a chore that involved handling, as he called
15 them, 'burning hot knives', burning hot crockery, in the
16 kitchen area?

17 MR ROLFE: Every account, my Lady, including the one my Lady
18 mentions.

19 LADY SMITH: Thank you.

20 MR ROLFE: The Daughters of Charity wish to use this closing
21 submission as an opportunity to apologise to anyone that
22 is a survivor of abuse, directly or indirectly, at any
23 establishment where members of their community were
24 involved.

25 In this closing submission, my Lady, the Community

1 would like to address survivors of abuse at both St
2 Joseph's and St Vincent's directly. To those survivors:
3 the Daughters of Charity have witnessed the accounts
4 that were provided. The Daughters of Charity are truly
5 and sincerely sorry for what occurred.

6 As was made plain during the opening submission, the
7 Daughters of Charity recognise the long-term and
8 debilitating effects of childhood abuse, both on
9 survivors and on those close to them. They have
10 witnessed the impact of those accounts on applicants.
11 They continue to be humbled by the courage shown by all
12 of the applicants that have come forward throughout this
13 phase of the Inquiry. For the pain endured, and that
14 continues to be endured by survivors of abuse at their
15 establishments, the Daughters of Charity are truly and
16 sincerely sorry.

17 As my Lady has heard, the Daughters of Charity are
18 no longer involved in the provision of care to children
19 with additional support needs. They haven't been so
20 involved since 1997. That notwithstanding, my Lady, the
21 Community will embrace the findings that your Ladyship
22 makes on the conclusion of this phase of the Inquiry and
23 will take forward any recommendations made.

24 Sister Eileen Glancy, Safeguarding Officer, and
25 Sister Ellen Flynn, former Provincial in Great Britain,

1 gave evidence on behalf of the Daughters of Charity.
2 They did so in their respective capacities as senior
3 figures within the Community. They were also present on
4 each day that evidence was led relating to St Vincent's
5 and St Joseph's.

6 Sister Eileen Glancy was present at St Vincent's
7 between 1971 and 1973. The Inquiry did not hear oral
8 evidence from Sister Eileen that related to her time at
9 St Vincent's. No questions were put to Sister Eileen in
10 relation to her own experience at St Vincent's and I --

11 LADY SMITH: Mr Rolfe, at the opening of Sister Eileen's
12 evidence, one of the things I said to her was to invite
13 her to raise anything that she considered we ought to be
14 asking her about.

15 And we do now know that she did work at St Vincent's
16 for two years. I remain very puzzled why, at some
17 point, she didn't volunteer in her evidence that she did
18 spend time working there and she had some relevant
19 evidence to give about that.

20 MR ROLFE: My Lady, as I propose to come on to,
21 Sister Eileen's time was spent in the kitchen at St
22 Vincent's and apart from a very short period during the
23 latter stages of her time in 1973, she had no contact
24 with children other than spending an hour or so during
25 the week with some visually impaired children.

1 LADY SMITH: Yes. She supervised visually impaired children
2 some evenings in the week, and she was working in the
3 kitchens, which I did hear evidence about during the
4 day. Her principal interest, I think she said in the
5 statement that we now have from her, was learning about
6 cooking, provision of food, in those sorts of
7 circumstances.

8 MR ROLFE: Well, my Lady, I can say only that the Inquiry
9 has now had the opportunity to take her statement and
10 that Sister Eileen has made herself available and is
11 willing to, and had been willing to throughout this
12 phase of the Inquiry, give evidence should the Inquiry
13 wish to hear from her but, when she gave her evidence,
14 in my submission, she did so in her capacity as
15 Safeguarding Officer.

16 LADY SMITH: We won't go round in circles here, Mr Rolfe.
17 I asked her to let me know if there was anything
18 that she felt she should have been asked about and
19 wasn't asked about and we aren't going to play lawyers
20 here. That was a general question: 'You were at St
21 Vincent's, tell me about, if we haven't asked you,
22 anything you knew about St Vincent's', and the way she
23 gave her evidence, you'd have thought she was never
24 anywhere near the place and all she knew about it was
25 what she had heard from surviving sisters.

1 End story.

2 MR ROLFE: I take my Lady's point.

3 LADY SMITH: Thank you.

4 MR ROLFE: If I may continue to address the issue of

5 Sister Eileen's evidence, my Lady --

6 LADY SMITH: Please do.

7 MR ROLFE: -- she was not named by any applicant, either as

8 a person involved in their care or teaching or as

9 a person who was responsible for, or aware of, any of

10 the events narrated. Under the terms of the Section 21

11 Notice, a detailed list of sisters who had served in any

12 capacity at St Vincent's was provided to the Inquiry.

13 That included Sister Eileen Glancy.

14 Now, my Lady, I must make plain that, for reasons

15 which those instructing me have explained in detailed

16 correspondence to the Inquiry, and for which they

17 sincerely regret, a cell in the relevant spreadsheet

18 relating to the question of whether Sister Eileen was

19 known to be living or deceased erroneously stated

20 'Unknown'. That is an error for which an apology has

21 been tendered and I reiterate that apology to my Lady

22 today.

23 For each of the applicants that gave evidence

24 relating to their own experiences of St Vincent's, there

25 were a number of sisters who were present during the

1 material times who are living. One of those was
2 Sister PUC , SNR of St
3 Vincent's from 1979 to 1985. In preparation for this
4 stage of the Inquiry, no statements were sought from
5 those sisters who were listed in that spreadsheet as
6 living. With one exception, none of those sisters named
7 by applicants are still living.

8 There were sisters who were still living at
9 St Vincent's at the times of residence of certain
10 applicants but they were not named by those applicants.
11 None of those sisters were called to give evidence
12 during this phase of the Inquiry.

13 LADY SMITH: What's your point about this, Mr Rolfe?

14 What's the point you are making?

15 MR ROLFE: The point I seek to make, my Lady, is albeit
16 Sister Eileen was present at St Vincent's at the
17 material time, she did not have a childcare role. The
18 Inquiry was furnished with a list of sisters who did
19 have a childcare role who were not spoken to and who
20 were not asked to give evidence, and it is on that basis
21 that it was no surprise that Sister Eileen was not asked
22 about her experiences at St Vincent's.

23 LADY SMITH: I'm not going to repeat what I said earlier,
24 Mr Rolfe. She's a very senior position; she's in a very
25 senior position in the Order now, and she didn't tell me

1 what I think she should have told me on the day she was
2 sitting there giving evidence.

3 MR ROLFE: Again, I take my Lady's point.

4 LADY SMITH: And you'll be well aware that decisions on who
5 to take statements from and who to make inquiries of,
6 which are made by Counsel to the Inquiry and the legal
7 team, will depend, amongst other things, on what
8 evidence is available to them that people who may be
9 named in the many, many, many documents we recover, that
10 they may have relevant evidence to give.

11 And I've no reason to believe that Counsel, or
12 anybody else in the legal team, were alerted to the
13 possibility that the sisters, who you say and seem to be
14 suggesting should have been called, and it's Counsel's
15 fault and the legal team's fault, had relevant evidence
16 to give.

17 MR ROLFE: My Lady, no criticism is intended to be levied at
18 the Inquiry team whatsoever.

19 LADY SMITH: Thank you.

20 Can we move on from Sister Eileen?

21 MR ROLFE: I'm obliged, my Lady.

22 LADY SMITH: And tell me what you have to say about the
23 other evidence.

24 MR ROLFE: Turning to St Joseph's, my Lady heard evidence
25 from Nuala Haller --

1 LADY SMITH: Yes.

2 MR ROLFE: -- a former member of the Community, on
3 13 May 2025. The account provided by Nuala Haller has
4 been accepted in full by the Daughters of Charity.

5 LADY SMITH: Yes.

6 MR ROLFE: The Inquiry also heard evidence from Sister
7 Catherine McErlean on 9 May 2025. She was present, my
8 Lady, at St Joseph's during two periods, between 1968
9 and 1971, when she worked with children; and between
10 1985 and 1995, when she was the Sister Servant or Local
11 Superior and later the Director of St Joseph's.

12 LADY SMITH: Can you remind me, as Sister Servant, did she
13 automatically have any role within St Joseph's? She
14 obviously had an important role when she became the
15 Director, but did Sister Servant mean that she had
16 a St Joseph's responsibility or not?

17 MR ROLFE: I'm afraid I can't remember that off the top of
18 my head, my Lady. My apologies.

19 LADY SMITH: Very well, thank you.

20 MR ROLFE: Sister Catherine spoke of the weekly visits from
21 a local GP and a doctor from the Sick Children's
22 Hospital. She spoke to the presence on a part-time
23 basis of a consultant psychiatrist. She spoke of
24 adopting an approach at St Joseph's that, if someone
25 couldn't walk in the door unannounced to see the place,

1 there was something wrong.

2 She spoke of being accountable to the Board of
3 Management, which consisted of a solicitor,
4 an accountant and a surveyor. Members of the management
5 team would report to the board and when she assumed the
6 role of Director at St Joseph's, she would walk the
7 premises to make herself seen. She spoke of changing
8 the management structure of St Joseph's assisted by
9 preparation of a questionnaire that could be completed
10 by families, social workers, GPs, representatives of the
11 Health Board or anyone that had any connection with St
12 Joseph's.

13 As a direct result of that initiative, the word
14 'Hospital' was dropped from 'St Joseph's Hospital'. The
15 sisters moved out of their accommodation to offer that
16 up to residents.

17 My Lady, I commend the account of
18 Sister Catherine McErlean to your Ladyship in support of
19 the proposition that, having accepted what was said by
20 Nuala Haller in relation to the periods she was present
21 between 1968 and 1973, there had been a positive change
22 to the way St Joseph's was run by at least 1985.

23 In conclusion, my Lady, the abuse of children in any
24 form is contrary to the values of the Daughters of
25 Charity, namely: compassion, respect, love, forgiveness,

1 justice and dignity. Since the Inquiry's inception, it
2 has been demonstrated that abuse of children took place
3 within establishments for which the Community were
4 responsible. That such abuse could and did take place
5 is diametrically opposed to the core values of the
6 Daughters of Charity.

7 The Daughters of Charity maintain their commitment
8 to working to put right the wrongs that occurred. My
9 Lady heard from Sister Ellen and Sister Eileen that the
10 community is a contributor to the redress scheme set up
11 in terms of the 2021 Act. Furthermore, the Daughters of
12 Charity strive to respond to anyone who has survived
13 abuse and are open to exploring new ways of offering
14 pastoral, emotional or practical support. Wherever it
15 has been made known to the community that such
16 emotional, psychological or practical support would be
17 welcome, that has been provided. Such support has been
18 and will continue to be provided on a confidential basis
19 at no cost to the survivors involved.

20 The Daughters of Charity earnestly invite any
21 further survivors who would welcome such support to make
22 contact with them. They are resolutely committed to
23 listening with compassion, to responding with gentleness
24 and cordiality and to respecting the wishes of
25 survivors.

1 In closing, the Daughters of Charity reiterate their
2 deep and sincere apology to all survivors and those
3 close to them who have dealt, and continue to deal, with
4 the enduring suffering caused by abuse under their care.
5 Thank you, my Lady.
6 LADY SMITH: Thank you very much, Mr Rolfe.
7 Well, we'll stop now for the morning break and then
8 I'll turn to the next set of submissions after that.
9 (11.25 am)
10 (A short break)
11 (11.47 am)
12 LADY SMITH: Now, the next set of submissions I'd invite are
13 those on behalf of the Good Shepherd Sisters, and
14 I think, Mr Henry, you are here for them; is that
15 correct?
16 Closing submissions by Mr Henry
17 MR HENRY: Yes, good morning, my Lady. I appear on behalf
18 of the Congregation of Our Lady of Charity of the Good
19 Shepherd who, for brevity, I will refer to as the Good
20 Shepherd Sisters.
21 LADY SMITH: Yes, thank you.
22 MR HENRY: My Lady, in the written submissions, I briefly
23 set out the history and establishment of the Good
24 Shepherd Sisters. I wouldn't intend to rehearse that
25 here. It has been rehearsed before to the Inquiry.

1 LADY SMITH: It has. I'm familiar with it, thank you.

2 MR HENRY: The Good Shepherd Sisters' interest in this phase
3 of the Inquiry relates to Woodfield Ladymary School in
4 Colinton, Edinburgh. At the outset of these
5 submissions, the Good Shepherd Sisters wish to make
6 clear, as was set out in the opening submissions to this
7 phase, my Lady, that they accept that abuse took place
8 at Woodfield Ladymary School. They apologise to all
9 those who suffered abuse at the school. The sisters did
10 not seek to question, challenge or minimise in any way
11 the evidence of the survivors who gave evidence to the
12 Inquiry.

13 It is accepted by the sisters that there will be
14 others who suffered abuse who have not come forward,
15 whether that be in relation to the criminal justice
16 system or to the Inquiry. The Good Shepherd Sisters
17 have the greatest sympathy for all survivors who have
18 suffered and for all those who were let down by the care
19 system.

20 Though the Good Shepherd Sisters' presence at
21 Colinton stretches back further, their involvement at
22 Woodfield Ladymary School was from 1967 to 1979. The
23 school was established in 1967 as a residential school
24 for -- and, my Lady, this is in the language that was
25 used at the time, rather than language that would be

1 used today -- 'maladjusted children'.

2 LADY SMITH: Yes, we've already touched on inappropriate
3 language such as that in the course of this morning's
4 submissions, and it's plain, looking at it through our
5 eyes now, that any language which infers that children
6 are to be blamed for how they are or denigrates them
7 just needs to be put in a bin and the lid needs to be
8 screwed firmly down in that bin. I think we have moved
9 on, but it must never be revived.

10 MR HENRY: Indeed, my Lady, and as Counsel to the Inquiry
11 and Ms McCall on behalf of INCAS identified, the
12 children who would have been at Ladymary School were
13 particularly vulnerable, and that's perhaps reflected in
14 the evidence that was led before the Inquiry.

15 LADY SMITH: Yes.

16 MR HENRY: The school was recognised as a residential
17 special school and both boys and girls were admitted.
18 The children who were resident at the school were of
19 primary school age up until the age of 12, and the
20 school closed in the summer of 1979.

21 The Good Shepherd Sisters understand that, while
22 there were those who wished for the school to remain
23 open and for the sisters to continue their work there,
24 it was the sisters who felt that they were unable to
25 continue that work at the school. This was due to

1 a combination of a reducing number of sisters and those
2 sisters who remained not being suitably qualified to
3 carry out that specialist work.

4 The Good Shepherd Sisters acknowledge that the
5 definition of abuse is wide-ranging and can manifest
6 itself in many forms. Survivors have given evidence of
7 physical and sexual abuse, and there's also evidence
8 before the Inquiry of the use of a quiet room at the
9 school. The Good Shepherd Sisters accept that the abuse
10 described took place at the school.

11 The Inquiry has, of course, heard evidence from
12 survivors relating to abuse carried out by
13 a Brian Dailey. Mr Dailey was employed at the school
14 between 1974 and 1977. As the Inquiry is aware,
15 Mr Dailey was convicted at the High Court of Justiciary
16 in both 2017 and 2022. The 2017 convictions in
17 connection with Woodfield Ladymary related to
18 a conviction for assault and a charge of lewd, indecent
19 and libidinous practices and behaviour, and the 2022
20 convictions were for lewd, indecent and libidinous
21 practices and behaviours, assault, indecent assault and
22 rape.

23 Those 2022 convictions related to 13 charges
24 involving seven children who were resident at the
25 school. Some of the charges related to behaviour which,

1 although not libelled as rape, involved behaviour that
2 is now understood to be rape and would be libelled as
3 rape if it were to happen at the present time, my Lady.

4 LADY SMITH: Thank you.

5 MR HENRY: The Good Shepherd Sisters acknowledge that simply
6 setting out the names of the charges of which Mr Dailey
7 was convicted does not adequately reflect the terrible
8 nature of the abuse carried out by him. The Inquiry has
9 the details of those charges and the evidence from
10 survivors. The Inquiry, of course, also has evidence
11 before it from Mr Dailey.

12 While Mr Dailey may continue to deny his crimes --
13 and ultimately, my Lady, it is, of course, a matter for
14 your Ladyship as to what, if anything, she makes of
15 those denials standing the convictions -- the Good
16 Shepherd Sisters do not deny that abuse was carried out
17 by Brian Dailey at Woodfield Ladymary School, and the
18 sisters again apologise to all those who suffered from
19 that abuse.

20 When giving evidence to the Inquiry,
21 Sister Rosemary Kean was asked for her reaction to
22 hearing the extent of Mr Dailey's offending. She stated
23 that she was absolutely disgusted, that she was
24 horrified when she heard what had happened.
25 Sister Rosemary stated that there weren't even words to

1 express the dismay and the shock and the horror. The
2 Good Shepherd Sisters share that disgust, shock and
3 horror at both the nature and the extent of Mr Dailey's
4 abuse.

5 It is accepted by the sisters that there was
6 an occasion when a complaint was made by parents of
7 a boy who was a pupil at Ladymary School in relation to
8 Brian Dailey. That complaint was that Brian Dailey had
9 sexually abused the boy when alone with him one evening.
10 The complaint was not referred to the police, but rather
11 to a consultant psychiatrist who was a professional
12 adviser to the school. In his evidence to the Inquiry,
13 Mr Dailey confirmed that he had in fact been interviewed
14 by the consultant psychiatrist on two occasions. While
15 Mr Dailey was suspended while the accusation was
16 investigated, it was judged by that consultant
17 psychiatrist that there was no basis for the accusation
18 and Mr Dailey was allowed to return to work.

19 The Inquiry also heard evidence from a survivor of
20 telling a female staff member that she had been made to
21 do stuff with a man and a boy the night before. She
22 stated that she had told this staff member she was
23 scared that it would happen again, and the staff
24 member's response was to lock her in her room at night.

25 The Inquiry also heard evidence from another

1 survivor that, after having made disclosure to an aunt,
2 her grandfather attended the school and spoke to the
3 mother superior and that Brian Dailey left the school
4 shortly thereafter.

5 The Good Shepherd Sisters accept there were systemic
6 failings in the way in which the complaints relating to
7 Brian Dailey were dealt with. As your Ladyship
8 identified when Sister Rosemary was giving evidence,
9 when the complaint relating to the sexual abuse of the
10 boy was made, it appears that the consultant
11 psychiatrist was relied upon to make a decision as to
12 whether the child was to be believed or not. He did
13 not, again, as your Ladyship identified, have any
14 special skills whatsoever to allow him to do that. And
15 again, as your Ladyship identified, the way in which
16 this individual was allowed to hold sway was not wise.

17 LADY SMITH: In a way, that understates it, doesn't it? It
18 was wholly inappropriate.

19 MR HENRY: Indeed, my Lady.

20 LADY SMITH: And, really, it amounted to an abrogation by
21 the sisters of what was their responsibility.

22 MR HENRY: My Lady, that is entirely accepted by the
23 sisters.

24 LADY SMITH: He wasn't an employee of the Order; he was
25 an outside consultant being used for advice. At the end

1 of the day, the responsibility was that of the sisters
2 to decide what to do.

3 MR HENRY: Indeed, my Lady, and the sisters do not try to
4 shy away from that today.

5 LADY SMITH: Yes, it's an important lesson for them to
6 learn, because you can see the influence that an
7 experienced male consultant psychiatrist might have
8 brought to bear over a community of sisters doing their
9 best, but perhaps feeling that, because he was a male
10 consultant psychiatrist, he would know best and better
11 than they did.

12 MR HENRY: Indeed, my Lady, and I do recall your Ladyship's
13 discussion with Sister Rosemary in relation to that
14 point, and your Ladyship's observation that perhaps
15 a male order may not have allowed another man to hold
16 such sway.

17 LADY SMITH: They may have stood up to him.

18 Thank you.

19 MR HENRY: My Lady, it is accepted by the sisters that the
20 manner in which these disclosures and complaints of
21 abuse were dealt with were not acceptable. There were
22 clear failures and deficiencies in the manner in which
23 they were dealt with.

24 As Sister Rosemary gave evidence to the Inquiry, in
25 her time at the school, there was no definition of abuse

1 and it never came into their thinking. There was no
2 training in relation to safeguarding and there were no
3 appropriate policies in place to deal with disclosures
4 and complaints of abuse.

5 And it is clear, my Lady, as I've indicated, to the
6 sisters that there were systemic failures at Woodfield
7 Ladymary School. There were not the appropriate
8 policies and procedures in place to follow when such
9 complaints were made. The practices at and ethos of the
10 school, and, indeed, of the sisters, were not sufficient
11 to prevent the abuse which took place there.

12 While these failures might have arisen from
13 a naivety or a failure to understand or appreciate the
14 nature of abuse, that is no excuse, my Lady. The
15 sisters apologise for those failures and apologise to
16 all those who suffered abuse as a result of those
17 failures.

18 There is one additional matter which the Good
19 Shepherd Sisters wish to address in relation to
20 Mr Dailey.

21 In his statement to the Inquiry, and again in
22 evidence, Mr Dailey stated that he received a letter
23 from solicitors from Ladymary School advising that
24 an award of compensation had been made to a witness and
25 that solicitors were trying to get him to pay them back.

1 Neither Sister Anne Josephine Carr, the current
2 Provincial Superior, nor Sister Rosemary Kean, her
3 predecessor, have any knowledge of any such letter being
4 issued to Mr Dailey. They did not instruct any such
5 letter to be sent to him. Checks made by those
6 instructing me, McSparran McCormick Solicitors, of their
7 files have not uncovered any such letter having been
8 sent by them. The sisters instructed checks to be made
9 with the insurance company who dealt with the reparation
10 action raised by the witness and survivor. They have no
11 record of any such letter being issued to Mr Dailey.

12 If Mr Dailey or the Inquiry is able to provide
13 a copy of the letter to which he referred in his
14 evidence, the sisters will use the information contained
15 within that letter to undertake all enquiries they can
16 to establish the circumstances of its sending.

17 LADY SMITH: Thank you.

18 Mr Henry, can you just confirm that, so far as
19 you're aware, McSparran McCormick are the only
20 solicitors that the sisters have used? I haven't heard
21 of other solicitors being instructed by them.

22 MR HENRY: My Lady --

23 LADY SMITH: Because Mr Dailey said his memory was it was
24 a letter from a solicitor.

25 MR HENRY: Yes, my Lady, as far as I'm aware -- and with

1 that proviso -- that is indeed the case. There may well
2 be other solicitors, perhaps in England, my Lady, given
3 it's a UK-wide order, and I do understand that there was
4 an insurance company who dealt with the claim, the
5 insurance company may have --

6 LADY SMITH: But Mr Dailey wouldn't have got a letter from
7 the insurers.

8 MR HENRY: Or solicitors used by the insurers, my Lady.
9 I simply don't know, my Lady. I'm perhaps trying to
10 make the point that I can't answer that question at the
11 moment.

12 LADY SMITH: No, indeed. But just to follow this through,
13 and hypothesise for a moment that somebody who had paid
14 compensation to a witness decided that they were going
15 to try and get the money back from Mr Dailey. I can see
16 that a solicitor on that person's behalf -- and it may
17 have been the insurers -- might write to the Order and
18 Mr Dailey. Surely they would tell the Order as well,
19 because Mr Dailey was their employee, you'd have
20 expected them to --

21 MR HENRY: One would have thought, my Lady, and the
22 information provided to me, as I set out, is that
23 neither Sister Anne Josephine Carr nor
24 Sister Rosemary Kean have any knowledge of the letter
25 and did not instruct that letter to be sent, my Lady.

1 And it's my submission that, given Mr Dailey's position
2 as someone who continues to deny abuse which has been
3 established to the criminal standard as having been
4 carried out, unless that letter can be produced,
5 my Lady, your Ladyship should be slow to accept that
6 evidence.

7 LADY SMITH: Indeed. And, of course, it's not to be assumed
8 that anybody engaging in these communications would keep
9 the Order in the loop, so you're back to communication
10 between an unknown solicitor and Mr Dailey, and does it
11 really come to you saying, if Mr Dailey is really
12 pushing that point, it's for him to produce the
13 documentary evidence, since he's relying on a document?

14 MR HENRY: Indeed, my Lady.

15 LADY SMITH: Thank you. Thank you.

16 MR HENRY: My Lady, the sisters consider that it is for you,
17 as Chair, to make any findings in fact that are seen
18 fit. The sisters consider that the evidence before the
19 Inquiry has established the sisters' involvement at the
20 school between 1968 and 1979. The nature and the extent
21 of abuse carried out at the school has been established,
22 and this includes both the abuse spoken to in evidence
23 before the Inquiry by survivors and the abuse of which
24 Brian Dailey has been convicted.

25 The Good Shepherd Sisters are no longer involved

1 with the provision of residential accommodation or care
2 for children in Scotland. They are a much reduced
3 presence in Scotland, with only a small number of
4 sisters living in this country.

5 The sisters have learned from the growing societal
6 understanding of abuse and growing understanding of the
7 importance of safeguarding. The Good Shepherd Sisters
8 have a range of written policies which require to be
9 followed as part of this work. And these policies
10 include safeguarding policies, and sisters undertake
11 training in relation to safeguarding and to keeping
12 themselves updated. The Good Shepherd Sisters
13 understand the importance of reporting all disclosures
14 or allegations of abuse to the appropriate authorities.

15 The Good Shepherd Sisters accept that harm was
16 caused to children, who are now adults, as a result of
17 their time spent at Woodfield Ladymary School. The Good
18 Shepherd Sisters acknowledge that that abuse included
19 physical and sexual abuse. They acknowledge the
20 suffering, trauma and pain that survivors have
21 experienced and their bravery in coming forward. The
22 Good Shepherd Sisters again apologise to all those who
23 suffered harm as a result of their time spent in the
24 care of the sisters.

25 The Good Shepherd Sisters deeply regret that

1 children who were placed in their care were abused. The
2 Good Shepherd Sisters welcome this Inquiry and
3 appreciate the importance of all voices being heard.
4 They regret that survivors have painful memories of the
5 time spent in their care, and they do not seek in any
6 way to challenge or minimise the experiences and
7 evidence of those survivors.

8 The Good Shepherd Sisters are grateful to the
9 Inquiry for the opportunity to participate in its work
10 and remain committed to assisting the Inquiry in any way
11 that they can.

12 LADY SMITH: Thank you very much indeed, Mr Henry.

13 Could I now please turn to the representation for
14 the Archdiocese of St Andrews and Edinburgh and I think
15 that's Mr Blair.

16 When you're ready, Mr Blair.

17 Closing submissions by Mr Blair

18 MR BLAIR: Good morning, my Lady.

19 These are the submissions of the Archdiocese of
20 St Andrews and Edinburgh in relation to three
21 institutions in which it was given leave to appear in
22 Phase 9: those are St Joseph's, Rosewell, Ladymary's,
23 Colinton and St Mary's Balnakeil.

24 The written submission for the Archdiocese sets out
25 the history of the Archdiocese and its current position.

1 I take the same position as Mr Henry that I suspect the
2 Inquiry is well aware of that and has seen these words
3 before, so that can be read shortly.

4 LADY SMITH: We certainly have, thank you.

5 MR BLAIR: The Archdiocese was granted leave to appear in
6 this phase on 9 April in relation to its connection to
7 the establishments mentioned. As the Archdiocese set
8 out in its opening submission, the decision to apply was
9 taken following the review of records held by the
10 Scottish Catholic Archives on its behalf in respect of
11 the institutions named in Phase 9 which were located
12 within the jurisdiction of the Archdiocese.

13 The review showed that it had records relating to
14 the three establishments named, which were all operated
15 and managed by autonomous religious orders in
16 conjunction with local authorities and regional health
17 boards. And accordingly, the Archdiocese's direct
18 involvement has been limited in this phase of the
19 Inquiry to supporting the Inquiry by supplying
20 documentation and observing the proceedings. The legal
21 team for the Archdiocese has liaised with the Inquiry
22 team and provided around 200 documents relating to the
23 three institutions.

24 Throughout the hearings in relation to St Joseph's,
25 Rosewell, Ladymary's, Colinton and St Mary's Balnakeil,

1 the Archdiocese has listened carefully to the evidence
2 presented. It's submitted that the available evidence
3 identifies that the Archdiocese did not have a role in
4 the management, running or day-to-day care of the
5 residents at the three establishments.

6 The Archdiocese would provide the establishments
7 with a chaplain and the Archbishop would, from time to
8 time, be informed of changes of religious personnel from
9 the autonomous orders who would leave and come to the
10 establishments within its dioceses. The Archbishop
11 would also, from time to time, be invited to attend
12 religious ceremonies being organised by these
13 establishments.

14 In terms of the evidence, the Archdiocese's
15 safeguarding officer was in attendance, along with
16 a legal representative, for the evidence heard on the
17 Days 530, 531 and 536, which were identified as being
18 the days relevant to the relevant institutions. The
19 Archdiocese has listened to the evidence of
20 Sister Catherine McErlean in respect of St Joseph's and
21 Sister Rosemary Kean in respect of Ladymary's. They had
22 regard to the witness evidence of the witness 'Alec' in
23 relation of his time at Ladymary, which was read into
24 the transcript on 4 June, and they attended for the
25 evidence of Nuala, a former employee of St Joseph's.

1 Lastly, the Archdiocese has read and accepts the
2 distressing evidence of abuse at Ladymary.

3 In terms of lessons to be learned from this
4 evidence, my Lady, the Archdiocese noted in particular
5 the comments of Sister Catherine McErlean that, in her
6 view, all staff need to know what abuse means and that
7 there are different facets to it. Similar sentiments
8 were echoed by Sister Rosemary Kean, who stated that we
9 need to pay attention when people have complaints. It's
10 not a matter of believing them or not; a complaint
11 cannot be ignored. Sister Rosemary further explained
12 that it was about creating a culture of care, a culture
13 of respect and a culture of justice, which the
14 Archdiocese believes is mirrored in its own modern
15 approach to safeguarding.

16 Further, the Archdiocese notes the evidence of
17 Nuala Haller, in that she reported allegations of abuse
18 to a local priest during her time at St Joseph's, and
19 she told the Inquiry that this allegation was not taken
20 seriously by the priest in question. The Archdiocese
21 accepts Nuala's evidence in that respect and it
22 apologises that such allegations were not dealt with as
23 they should have been. What Nuala describes as being
24 her experience is not reflective of the standards the
25 Archdiocese expects in relation to safeguarding which

1 this submission will address.

2 If an allegation of abuse were to be received now by
3 a priest, it would be expected to be reported to the
4 safeguarding department of the Archdiocese. Allegations
5 relating to safeguarding and abuse must always be
6 treated with the utmost seriousness, care and urgency,
7 and this is reflected, in my submission, in the
8 Archdiocese's current safeguarding practices, which
9 include mandatory reporting of allegations. If any
10 report of abuse was received and not escalated, this
11 would be a matter of deep concern for the Archdiocese.

12 The Archdiocese wishes to continue to emphasise that
13 it takes allegations of abuse seriously. It's
14 previously advised your Ladyship of the current and
15 developing safeguarding work being carried out by the
16 Archdiocese in respect of children at the closing
17 submissions in respect of Phase 8 on 13 February this
18 year, and the position remains the same.

19 To summarise, the Archdiocese adheres to the
20 safeguarding procedures covering the whole Catholic
21 Church in Scotland and is monitored by the Scottish
22 Catholic Safeguarding Standards Agency. The Archdiocese
23 has several safeguarding structures in place. These
24 include the diocese risk assessment management team, who
25 oversee safeguarding practice, focusing on risk and

1 chaired by an independent lay professional, and the
2 safeguarding advisory group. National meetings of
3 safeguarding leads also take place regularly and the
4 safeguarding adviser is available to brief and answer
5 questions.

6 Each diocese is bound by arrangements in the
7 national manual, 'In God's Image', which outlines the
8 safeguarding arrangements within the diocese, which
9 includes the mandatory reporting of allegations to the
10 relevant statutory authorities.

11 To conclude, my Lady, the Archdiocese continues to
12 follow the work and findings of the Inquiry to date, in
13 particular where this relates to the context of
14 religious care and education. The Archdiocese's
15 safeguarding adviser, Scott Mackenzie, is in attendance
16 today, and the Archdiocese thanks the Inquiry for the
17 opportunity to make this submission, and will continue
18 to undertake to assist the Inquiry whenever that is
19 needed.

20 LADY SMITH: Thank you very much, Mr Blair.

21 MR BLAIR: Thank you.

22 LADY SMITH: Now, if I could turn next to representation for
23 Save the Children, that's Ms Cassidy. Now, I know you
24 are also here for Seamab; is that correct?

25 MS CASSIDY: That's correct, my Lady.

1 LADY SMITH: What order do you want to take these in?

2 MS CASSIDY: I'll start with Save the Children first.

3 LADY SMITH: Thank you very much, thank you.

4 Closing submissions by Ms Cassidy

5 MS CASSIDY: Thank you, my Lady.

6 I appear on behalf of Save the Children Fund. Also
7 present today is Claire Telfer, Head of Scotland, and
8 Bonike Bracewell, General Counsel and Company Secretary.

9 Representatives of Save the Children were present or
10 attended remotely to hear all applicant evidence. Your
11 Ladyship also heard from Cat Carter, Director of
12 Safeguarding, and Dan Paskins, Executive Director for
13 Policy, Advocacy and Campaigns at Save the Children UK.

14 Save the Children remains true to the commitment
15 made in opening submission to listen to survivors'
16 experiences, to reflect on all the evidence read and
17 heard and to learn from past failings.

18 Save the Children offers its sincere, unreserved and
19 heartfelt apologies to all who suffered harm and abuse
20 as children while in its care.

21 Your Ladyship has heard the evidence on the history
22 of Harmeny School and Save the Children's management and
23 operation from 1958 until 1995. By the 1980s, the
24 organisation's residential care establishments were
25 exceptions to Save the Children's overall UK strategy.

1 In 1991, Save the Children commissioned
2 an independent review of its work and the Kahan Report
3 led to the recognition that running the school was
4 incongruent with the rest of Save the Children's
5 operations. Save the Children then helped establish
6 an independent charity, Harmeny Education Trust Limited,
7 and transferred the school to the trust from
8 21 December 1995.

9 Harmeny School is the only establishment Save the
10 Children have operated in Scotland, save for wartime
11 evacuation centres, and the organisation has not
12 operated any residential schools in the UK since 1995.

13 Your Ladyship has Save the Children's written
14 submission and I would adopt that in its entirety. I do
15 not intend to take your Ladyship through each line of
16 the submission; rather, to highlight key sections.

17 LADY SMITH: Thank you.

18 MS CASSIDY: Let me turn to findings of fact that your
19 Ladyship may consider making in respect of Save the
20 Children's management and operation of Harmeny until
21 1995.

22 Firstly, that there was a lack of effective
23 oversight by Save the Children; that there was no or no
24 effective complaints system in place at Harmeny School,
25 meaning that children did not have a clear or formal way

1 to share allegations, concerns or feedback with staff;
2 that the use of corporal punishment was authorised at
3 Harmeny School, even after it was banned in state-funded
4 schools in Scotland and by Save the Children UK, and
5 that there was no or no adequate oversight of its use;
6 that from 1960 until 1995, the number of staff employed
7 by Harmeny School was insufficient for the complex needs
8 of the children; that the level of skill, training and
9 supervision of many of the staff employed at Harmeny
10 School was insufficient for the complex needs of the
11 children; that members of staff physically assaulted
12 children at Harmeny School; that members of staff
13 verbally and emotionally abused children at Harmeny
14 School; and, finally, that Harmeny School did not have
15 effective safeguarding procedures in place or failed to
16 undertake effective safeguarding to prevent children
17 from suffering abuse at the school.

18 My Lady, the written submission sets out in more
19 detail where the evidence comes from for those findings
20 and provides a summary of the applicant evidence heard
21 during this phase. I would invite your Ladyship to take
22 that into account.

23 LADY SMITH: Thank you, it's very helpful that's set out
24 there.

25 MS CASSIDY: My Lady, let me turn from findings of fact to

1 acceptance of failures.

2 Save the Children agree that children experienced
3 abuse at Harmeny school, that unacceptable practices
4 took place, that there were failures in safeguarding
5 systems and that insufficient action was taken to
6 prevent children from suffering abuse. Accountable
7 management of Harmeny School was lacking and out of
8 touch with the day-to-day life of the children and
9 staff. Save the Children accepts that there were
10 failures in its response to abuse and allegations of
11 abuse.

12 Your Ladyship will have appreciated from Ms Carter
13 and Mr Paskins's evidence how seriously Save the
14 Children takes these matters. They recognise the
15 profound and enduring impact on children and clearly
16 understand Save the Children's duty to confront and
17 acknowledge their failings in order to prevent
18 recurrence.

19 Let me turn then to some of the specific failures
20 which have emerged from the evidence.

21 The lack of effective oversight on the part of Save
22 the Children resulted in Harmeny School's culture and
23 rules changing in line with the headteacher of the day,
24 rather than following any overarching policy. This was
25 compounded by the physical distance between the school

1 and Save the Children's management, the lack of
2 reporting mechanisms for complaints, and the absence of
3 regular governance reviews by Save the Children.

4 This absence of effective oversight contributed to
5 circumstances where the use of corporal punishment was
6 authorised by the Headteacher in the 1990s, despite Save
7 the Children issuing guidance in 1977 that banned its
8 use in their residential and daycare establishments.
9 Mr Paskins was horrified by the headteacher's guidance
10 in the 1990s that permitted staff smacking or slapping
11 children, albeit in extreme circumstances, as it
12 endorsed actions that were not just unacceptable by the
13 standards of the time, but also illegal. There are no
14 circumstances in which a child should be physically
15 assaulted.

16 That the role of family counsellor was also
17 undertaken by the headmaster's wife in the 1980s and
18 1990s, with significant authority and influence over the
19 management of the school, contributed to an overall lack
20 of accountability and may have deterred children from
21 using the counsellor as a trusted confidant.

22 Supervision and training of staff was seriously
23 deficient and inappropriate behaviour went unnoticed or
24 unchallenged. Residential care staff received minimal
25 support and appear to have been seen as an adjunct to

1 education. We heard evidence that many residential
2 staff were young, inexperienced and required to learn on
3 the job with no formal training. The focus for care
4 staff was on containment and survival, rather than about
5 care and treatment. But taking a containment approach
6 to children who had likely experienced abuse prior to
7 arriving at Harmeny was completely inappropriate and
8 unlikely to support their recovery.

9 Failures to listen to children and to involve them
10 in decision-making represented a missed opportunity to
11 learn from them, to identify and prevent abusive
12 behaviour and to improve children's experiences at the
13 school. These failures contributed to poor
14 decision-making following reports of abuse, one example
15 being a member of staff being allowed to remain in post
16 despite them admitting that they had physically abused
17 a child.

18 We heard evidence of children waiting until they
19 were outside of the school or speaking with adults
20 external to the school to disclose abuse. One
21 particularly heartbreaking account from the Kahan Report
22 described a young boy who shared a secret note with one
23 of the reviewers disclosing his unhappiness which the
24 staff had not noticed. That he was only able to make
25 this disclosure to someone external to the school

1 highlights a failure by the school and Save the Children
2 to provide a mechanism for children to share their
3 concerns or to encourage and empower them to do so.

4 We heard evidence that a child had waited until she
5 was outside of the school to report a physical assault
6 by a member of staff, following questioning from her
7 social worker. Ms Carter commented that this incident
8 underlines the importance of staff engaging in their
9 work with professional curiosity, and reflecting on
10 observations to gain a complete understanding of
11 an individual's situation, rather than accepting
12 information at face value. By recognising subtle signs
13 of harm and making connections, staff can identify
14 potential abuse and intervene early to prevent harm.

15 There were missed opportunities to reflect, to learn
16 and to improve practices for the benefit of the
17 children, and this was evidenced by the fact that
18 another instance of physical abuse was carried out by
19 the same member of staff a matter of weeks later.
20 Although the latter incident resulted in their
21 dismissal, the second incident could easily have been
22 prevented had the school taken appropriate disciplinary
23 action following the first incident.

24 Inappropriate forms of discipline, such as the
25 forced undressing and bathing of children and violent

1 methods of restraint by members of staff, should never
2 have occurred. That forcible undressing and bathing was
3 used as a form of punishment within one unit at the
4 school, and occurred seemingly unchallenged until it was
5 raised by external reviewers in the 1990s, highlights
6 the inadequacy of staff training and the lack of
7 understanding on the part of staff of the serious harm
8 such actions would cause.

9 As many of the children accommodated at Harmeny
10 School had suffered significant abuse prior to
11 admission, this form of punishment was likely to serve
12 as an aggravation or continuation of the original abuse.
13 These actions were fundamentally misaligned with Save
14 the Children's approach to safeguarding and their desire
15 to respect, uphold and promote children's rights.

16 That staff believed they could behave in this manner
17 without any sense of accountability or remorse when
18 confronted, and that children were too frightened to
19 speak out, stands as a grave indictment of the school's
20 culture, its leadership, the adequacy of staff training
21 and the absence of effective reporting mechanisms and
22 procedures.

23 Let me turn to addressing the identified failures.

24 Your Ladyship has seen that one of the reasons why
25 the Kahan Report was commissioned was to make

1 recommendations about the future of the school,
2 including its governance arrangements. Save the
3 Children followed the recommendation to transfer the
4 school to an independent charity, Harmeny Education
5 Trust Limited, which was completed in 1995.

6 Save the Children accepts that when the decision was
7 made to establish Harmeny School, Save the Children
8 failed to consider whether it was best placed to provide
9 a service for children with additional social, emotional
10 and behavioural needs. There is no evidence that Save
11 the Children conducted a thorough analysis to determine
12 what it would need to do to ensure that children felt
13 and were safe and protected and at the heart of all
14 decision-making within the school.

15 Save the Children no longer operates residential
16 schools in the UK and its work now focuses on early
17 years support, providing emergency grants, advocacy and
18 campaigning and community engagement within the UK, all
19 to ensure that every child in the UK has the opportunity
20 to thrive, regardless of their background.

21 Save the Children is governed by a Board of Trustees
22 who come from diverse backgrounds and include those with
23 experience in child protection. There is a dedicated
24 safeguarding committee and safeguarding trustee, and
25 safeguarding is embedded into the governance framework,

1 with regular reporting to the safeguarding committee,
2 the audit and risk committee and the full Board of
3 Trustees.

4 Save the Children's safeguarding strategy has
5 a governance pillar which includes an emphasis on
6 embedding safer recruitment practices, reinforcing
7 a strong speak-up culture, with mechanisms to encourage
8 concerns to be raised, and carrying out prompt, fair and
9 survivor-centred investigations.

10 Save the Children also operate a zero tolerance
11 policy towards inaction when safeguarding concerns are
12 raised, ensuring that child abuse is not taking place
13 anywhere in its business or in any of its supply chains
14 or partnerships. Their protocol applies to all persons
15 working with them or on their behalf and applies during
16 or outside of working hours every day of the year. All
17 persons must report any abuse or suspicion of abuse
18 within a 24-hour time limit and hard evidence is not
19 needed for a report to be officially logged and
20 investigated.

21 Save the Children recognises that an apology, while
22 important, is not sufficient on its own. It is
23 necessary to take action to provide redress to those who
24 have suffered as a consequence of abuse at Harmeny.
25 Save the Children has sought to do so by participating

1 in Scotland's Redress Scheme for survivors of historical
2 child abuse in care in Scotland, and agreeing to provide
3 written apologies whenever requested. Save the Children
4 recognises the importance of this scheme to survivors
5 and acknowledges the strength and courage of all those
6 who came forward, campaigned for and shaped the Redress
7 Scheme.

8 Save the Children is committed to playing its part
9 in the collective national effort to address historic
10 child abuse. Survivors want and deserve to be listened
11 to, heard and believed, and to be treated with dignity
12 and compassion. Save the Children strives to make sure
13 that children's voices continue to profoundly shape the
14 way Save the Children works, as well as its
15 organisational culture.

16 Finally, Mr Paskins concluded his evidence with
17 an apology on behalf of Save the Children. Let me
18 repeat that apology now.

19 Save the Children offers its sincere, unreserved and
20 heartfelt apologies to anyone who suffered harm and
21 abuse as children while in its care. It apologises for
22 the failures that allowed abuse to happen and for the
23 fact that it failed to address obvious concerns. Save
24 the Children apologises for the impact that has had and
25 continues to have on those lives. It acknowledges its

1 responsibility to promote the welfare of all children,
2 to keep them safe, and to take action in relation to any
3 incidents of abuse.

4 There is no time limit on Save the Children's
5 accountability. Nothing can undo those wrongs, but Save
6 the Children is committed to striving to protect the
7 children and families it works with to the highest
8 possible standards. Save the Children is fully
9 committed to working with the Inquiry, learning from the
10 applicants' evidence and the reports when published.

11 Thank you.

12 LADY SMITH: Thank you very much.

13 And then to Seamab?

14 MS CASSIDY: Yes.

15 My Lady, I also appear on behalf of Seamab today.

16 LADY SMITH: Thank you.

17 MS CASSIDY: Also present is Stuart Provan, Chief Executive
18 Officer, and three of Seamab's trustees: Bob Cook,
19 Vice-Chair of the Board of Trustees, Andrew Chalmers and
20 Derek Young.

21 Your Ladyship will have seen that Mr Provan and
22 Seamab's trustees were present for all of the applicant
23 evidence. It was and is a matter of importance to them,
24 not only that Seamab contributes fully to this phase,
25 but that they hear directly from the mouths of those

1 most affected.

2 Your Ladyship has heard the evidence on the history
3 of Lendrick Muir and Seamab. Lendrick Muir School
4 opened in 1962 and closed in 1998 following financial
5 problems. Seamab School opened in 1988 and continues to
6 provide schooling, care and therapy on a 52-week basis
7 for children from ages 5 to 18.

8 Your Ladyship has Seamab's written submission and
9 I would adopt that in its entirety. As in my previous
10 submission, I do not intend to take your Ladyship
11 through each line, but will highlight some key sections.

12 Turning to specific findings and facts your Ladyship
13 may consider.

14 Firstly, that the number of children accommodated at
15 Lendrick Muir exceeded appropriate levels in the 1970s
16 and early 1980s.

17 That there was endemic bullying at Lendrick Muir and
18 that this occurred with the knowledge of staff.

19 That children were made to undertake physical
20 exercise if they were not going to sleep and that
21 collective physical exercise for a whole dormitory was
22 also a form of enforcing school rules.

23 That there was widespread absconding from
24 Lendrick Muir with no or no adequate exploration with
25 children of the reasons for them running away.

1 That members of staff physically assaulted children
2 at Lendrick Muir in the 70s and 80s.

3 That Lendrick Muir failed to establish and
4 communicate clear procedures for pupils to raise
5 concerns or make formal complaints about their care.

6 That Lendrick Muir did not have an effective
7 safeguarding procedure in place or failed to undertake
8 effective safeguarding to prevent a child being taken
9 alone on overnight trips with a male member of staff and
10 sharing a room with one bed between 1978 and 1981.

11 That between 2010 to 2013 and again in 2014, members
12 of staff failed to investigate and pass on child
13 protection concerns to senior management, meaning the
14 school was not in a position to implement their child
15 protection procedures and children were therefore at
16 risk of harm.

17 That members of staff at Seamab School used
18 inappropriate physical interventions and restraint
19 techniques.

20 That staff at Seamab School failed to properly and
21 consistently record the reasons for using restraint
22 techniques, preventing effective oversight and
23 meaningful analysis of its use, which in turn hindered
24 efforts to safeguard pupils and improve practice.

25 That children frequently absconded from Seamab with

1 no adequate reflection on the reasons for absconding.

2 And finally, during 2013 and 2014, that Seamab
3 School received repeated Care Inspectorate inspections
4 that identified significant areas of concern and for
5 improvement and that in the period from around 2014
6 onwards, there was significant improvement in the
7 grading of the school.

8 My Lady, the written submission sets out in more
9 detail where the evidence comes from for those findings
10 and provides a summary of the applicant evidence heard
11 during this phase. I would invite your Ladyship to take
12 that into account.

13 One particular chapter of evidence that stood out to
14 Mr Provan and Seamab's trustees came from an applicant
15 with the pseudonym 'Alex'. 'Alex' attended
16 Lendrick Muir in the 1970s and 1980s and described being
17 isolated and groomed by one of his teachers, 'Francis'.
18 He recalled 'Francis' giving him a key to his room,
19 offering him alcohol and taking him on overnight trips
20 alone. 'Alex' stated that he was sexually abused by
21 'Francis' on several occasions.

22 Staff at Lendrick Muir were aware of a decline in
23 'Alex's academic performance and noted that he was
24 overdependent on 'Francis'. Even other children at the
25 school commented on the time they spent together.

1 Although 'Francis' denied abusing 'Alex' in his
2 evidence, he accepted that his actions could have been
3 misconstrued as grooming. Mr Provan and Seamab's
4 trustees, and I suspect anyone who heard 'Francis's'
5 evidence, did not consider him to be credible and were
6 shocked by his attempts to justify his actions.

7 Your Ladyship will consider all of the evidence and
8 reach findings in fact in light of that, but what can
9 immediately be said is that there should have been no
10 occasion when a teacher was allowed to give pupils
11 alcohol, to isolate and groom them and then to take them
12 away from the school without the school immediately and
13 decisively intervening to prevent it. That this
14 occurred seemingly unchallenged and with the full
15 knowledge of the school left Mr Provan and the trustees
16 speechless. It was unconscionable. Seamab acknowledges
17 the strength and resilience of all those who came
18 forward to share deeply personal and distressing
19 experiences.

20 My Lady, let me turn from findings of fact now to
21 acceptance of failures.

22 As I have set out, Seamab accept that children
23 suffered abuse at Lendrick Muir and Seamab and, as
24 Mr Provan said in his evidence, that the systems in
25 place failed to protect children. Seamab accepts that

1 there were failures in its response to abuse and
2 allegations of abuse. Seamab apologises for that and
3 your Ladyship will have appreciated, from his evidence,
4 how seriously Mr Provan takes these matters,
5 particularly the lasting impact this has had on children
6 and the responsibility of the school to ensure that
7 there is no repetition.

8 Let me set out some specifics of that failure.
9 Bullying was rife at Lendrick Muir and reported at
10 Seamab. Where it was reported, there is no evidence of
11 effective action being taken to prevent it. On the
12 contrary, it was suggested in evidence that staff viewed
13 it as a way to toughen up children.

14 Mr Provan has reflected on the staff-to-pupil ratio
15 at Lendrick Muir, noting that the low numbers of care
16 staff created an environment in which staff allowed
17 older children to bully and control younger children as
18 a means of supporting staff to maintain order within the
19 school. This allowed already vulnerable children to
20 feel unsafe in a setting that should have ensured they
21 felt happy and secure.

22 Supervision and training of staff was seriously
23 lacking and meant that staff were ill-equipped to
24 address the range of specific needs of the children
25 accommodated. Behaviours which ought to have been

1 noted, challenged and addressed either went unnoticed or
2 unchallenged.

3 Restraint techniques were not properly taught,
4 implemented, supervised, recorded or reviewed at
5 Lendrick Muir and remained an issue at Seamab, as
6 identified by external inspection reports in 2014. We
7 heard evidence of incidents where intervention
8 techniques were applied inappropriately despite
9 training, resulting in staff being disciplined. That
10 the same member of staff was involved in two separate
11 inappropriate physical interventions in 2011 and 2013,
12 suggest weaknesses in the disciplinary process and
13 a culture of impunity. As INCAS identified in their
14 closing submissions, such a culture does not protect
15 children but is likely to create more victims.

16 Applicants who attended Lendrick Muir spoke of being
17 unsure of how to make formal complaints and having no
18 confidence that, when they reported issues, they would
19 be taken seriously and that meaningful action would
20 follow. The absence of clear complaint mechanisms,
21 coupled with pupils' lack of trust in staff
22 responsiveness, suggest that there was a gap in
23 safeguarding practice and accountability structures,
24 which likely discouraged pupils from raising concerns.
25 This should never have occurred and Seamab firmly

1 believe that children should always have confidence that
2 their voices will be heard and responded to
3 appropriately.

4 Let me turn now to addressing the identified
5 failures.

6 My Lady, I will start with the disturbing evidence
7 from 'Alex' regarding the grooming and sexual abuse by
8 'Francis'. No member of staff at Seamab is permitted to
9 take a child on a trip overnight on a one-to-one basis.
10 Any external excursions with children are planned in
11 advance and must be approved by senior management.

12 Seamab deliver face-to-face child protection
13 training annually to all staff. This training also
14 forms part of staff inductions and includes modules on
15 safeguarding responsibilities at all levels of the
16 organisation. The training includes how to respond to
17 disclosures of abuse, how to identify specific types of
18 abuse or abusive situations and how to effectively
19 record a disclosure so it can be used to safeguard
20 a child.

21 Seamab's contracts of employment have now been
22 updated to note that all staff have a duty to report
23 concerns about possible and actual harm or abuse towards
24 children and to accurately record those concerns in
25 accordance with Seamab's child protection policy.

1 There are designated child protection officers
2 within Seamab who are available to discuss concerns,
3 oversee decision-making processes, to provide advice and
4 support and to ensure compliance with policies. All
5 matters which may have child protection implications
6 must be reported to a designated child protection
7 officer and the senior on duty as quickly as possible.
8 Where concerns relate to employees, volunteers and
9 trustees, they must also be reported to the Head of
10 Education or the Head of Care and the CEO. Staff
11 contracts note that a failure to report may result in
12 disciplinary action up to and including termination.
13 A copy of the child protection policy is provided to all
14 new staff members and discussed during their induction
15 and annual training.

16 Your Ladyship has seen that there was a change of
17 approach from around 2011 onwards. There was a new
18 Chief Executive, Joanna McCreadie. Education and care
19 services were restructured with the deliberate intention
20 of challenging long-established practices, to identify
21 and address concerns relating to staff behaviour and to
22 promote continuous improvement. There was a refocusing
23 of efforts, helped and guided in part by responding to
24 Care Inspectorate visits and the reports which followed.

25 Staff-to-child ratios have improved considerably.

1 Seamab currently support 25 children, with 19 receiving
2 residential care and six day students. Seamab currently
3 have 65 full-time staff, 32 part-time staff and 15
4 sessional staff.

5 In the care setting, there is one staff member to
6 every two children, and a senior on duty covering the
7 care campus at all times. Seamab provide additional
8 staffing resource should any child be assessed as
9 requiring one-to-one support.

10 In the school, there is one teacher and two
11 education support workers for each class, with class
12 sizes ranging from four to six pupils.

13 Current staff-to-child ratios mean that staff can
14 work with smaller groups or with children on
15 a one-to-one basis to provide more dedicated support,
16 with a better understanding of each child's background.

17 Seamab train staff using PACE techniques:
18 playfulness, acceptance, curiosity and empathy. This
19 supports an understanding of the attachment challenges
20 that children will experience as a result of their own
21 trauma.

22 Staff are supported to be reflective, to seek to
23 understand the reasons behind behaviours that may be
24 presented, and to be part of a team that can help
25 children to build resilience and to achieve their full

1 potential.

2 Seamab have an in-house educational psychologist,
3 who works four days a week, and they are part of a wider
4 support team for children and staff, but also work with
5 children on a one-to-one basis.

6 All staff are trained in de-escalation and
7 therapeutic crisis intervention techniques. Seamab have
8 three trainers for Crisis Prevention Institute training,
9 and this training is person-centred and trauma-informed.
10 It includes suggested de-escalation approaches to
11 decrease challenging behaviour and avoid physical
12 intervention where possible. Staff discuss incidents of
13 physical intervention with children after the fact, when
14 those involved have had the opportunity to reflect.
15 Children are encouraged to share their views on the best
16 strategies to support them.

17 Mr Provan, in his evidence, spoke of the Restraint
18 Reduction Associate. They chair Seamab's Restraint
19 Reduction Committee, meeting every month to review the
20 incidences of physical intervention. They collate
21 statistics to track its use, the severity of incidents
22 and to analyse trends. The associate speaks to staff
23 after any physical intervention to understand why it was
24 used and to inform improvements. Since the Restraint
25 Reduction Associate joined in October 2023, Seamab have

1 seen a reduction of 63 per cent in incidents involving
2 restraint or safe holding.

3 If staff are involved in any physical intervention,
4 they must complete an incident and safety intervention
5 report. The report promotes reflection on the incident
6 and requires staff to provide detailed reasoning behind
7 any intervention, with a checklist of those to be
8 notified. It also requires staff to specify what
9 disengagement techniques were used to de-escalate
10 a situation, and the reports are checked by line
11 managers and employees are offered a debrief session,
12 which is recorded. The report also --

13 LADY SMITH: That, of course, Ms Cassidy, is a very
14 important factor. It's not good enough to simply have
15 training, have the incident and move on; there needs to
16 be a proper, thorough debriefing of: 'How did it go?
17 You've got your reasons, that's why you were doing it;
18 you hoped, we take it, to achieve, by that, the best
19 outcome for the child. Did that happen, or didn't it?
20 And if it didn't, why not?'

21 MS CASSIDY: Indeed, my Lady, I think that's the only way to
22 learn from those situations.

23 The report also includes a children's incident
24 reflection form. That is designed to be completed with
25 the child and prioritises their sense of safety and

1 emotional regulation before discussing the incident.

2 Seamab's Head of Care conducts quality assurance
3 checks on all paperwork relating to physical
4 interventions to ensure adherence to recording protocols
5 and to identify any deviation from appropriate
6 procedure.

7 Staff at Seamab are no longer instructed to focus on
8 consequences following inappropriate behaviour, but
9 instead to deal with incidents on a case-by-case basis,
10 working with the children. Staff are encouraged to take
11 time to discuss any inappropriate behaviour with the
12 child to understand the reason behind their actions and
13 what message they may be trying to convey. There is now
14 an emphasis on how staff can provide help and support to
15 children to get to the root of the issue that is causing
16 them problems.

17 Finally, Mr Provan concluded his evidence with
18 an apology on behalf of Seamab. Let me wholeheartedly
19 repeat that apology now.

20 Seamab apologises for any and all harm or abuse
21 suffered by any child at Lendrick Muir and Seamab. They
22 apologise for the failures that allowed abuse to happen
23 and failed to address obvious concerns. They apologise
24 for the impact that has had and continues to have on
25 those lives.

1 At the heart of Seamab is a dedication to ongoing
2 improvement in their care, education and support of
3 children and young people. They want to play their part
4 in the continuous improvement of residential school
5 services and shape a culture that is based on care,
6 compassion, support and empathy. Their commitment to
7 the Inquiry and to learning from the evidence and
8 forthcoming reports is but one aspect of this.

9 Thank you, my Lady.

10 LADY SMITH: Thank you very much, Ms Cassidy.

11 Could I now move to representation for Harmeny
12 Education Trust Limited and, of course, that's the
13 organisation which, if I remember rightly, took over the
14 school from Save the Children in 1995. Is that right?
15 It's you, Mr Ross?

16 Closing submissions by Mr Ross

17 MR ROSS: Yes, indeed, my Lady, that's quite correct, and it
18 continues to be so responsible today.

19 LADY SMITH: Yes.

20 MR ROSS: At the outset, may I say that Harmeny has valued
21 the opportunity to participate in this phase of the
22 Inquiry's hearings. Gavin Calder, the Chief Executive,
23 and Jennifer Scott, the Chair of the Board, and other
24 trustees, have attended or viewed a number of the
25 evidence sessions, and a written closing submission on

1 behalf of the trust has been provided to the Inquiry.

2 LADY SMITH: Yes, I have that.

3 MR ROSS: That written submission contains Harmeny's

4 detailed reflections and conclusions in relation to the

5 evidence led at the oral hearings, but also the other

6 evidence which has been received by the Inquiry in

7 relation to Harmeny.

8 LADY SMITH: Thank you.

9 MR ROSS: I don't propose to read out that submission, my

10 Lady, and in my closing statement today, I have been

11 asked to speak to five key themes from the written

12 submission that Harmeny considers to be of particular

13 importance.

14 LADY SMITH: Thank you.

15 MR ROSS: Those themes, my Lady, are firstly the abuse of

16 children at Harmeny; secondly, failings on the part of

17 Harmeny; thirdly, an apology; fourthly, changes at

18 Harmeny; and, fifthly, and briefly, looking to the

19 future.

20 LADY SMITH: Thank you.

21 MR ROSS: Turning then to the substance of what Harmeny

22 would like to say today, it may be appropriate to begin

23 with the evidence in relation to incidents of child

24 abuse occurring at the school, and here I pick up on

25 what is written at paragraphs 17 to 24 of the

1 submission.

2 LADY SMITH: Thank you.

3 MR ROSS: By way of preface to that, the Inquiry has heard
4 that while children come to Harmeny from a diversity of
5 circumstances, all of them have suffered from trauma in
6 their early years. As a result of this, the children at
7 Harmeny have complex additional support needs, which
8 demand a highly specialist approach to their care and
9 education.

10 In these circumstances, it is submitted that the
11 requirement for the highest standards of teaching, care
12 and child safeguarding is self-evident. The children at
13 Harmeny should feel safe, nurtured and be able to enjoy
14 their childhood and recover from their experience of
15 trauma.

16 It is therefore with immense regret that Harmeny
17 submit that the evidence before the Inquiry establishes
18 that acts of child abuse have been committed against
19 children at Harmeny School during the period between
20 1995 and 2014, for all of which it was responsible for
21 the school, and that the abuse has included incidents of
22 physical and verbal abuse by members of staff upon
23 children. Harmeny has also acknowledged that there have
24 been incidents of abuse between children at the school.

25 In the written submission, Harmeny have set out

1 details of five occasions -- and those are at
2 paragraphs 19 to 20 -- on which children were, in my
3 submission, undoubtedly abused in this way by members of
4 staff at the school, and it has referred to the evidence
5 in relation to those incidents which the Inquiry has,
6 both from Harmeny's response to the Section 21 Notice,
7 based on its own review of records and in the written
8 and oral evidence of the current Chief Executive,
9 Gavin Calder, and his predecessors. Four of those
10 incidents of abuse occurred between 1996 and 1998, and
11 another incident occurred in 2013.

12 In my submission, the occurrence of these incidents
13 is well documented in the evidence and the Inquiry can
14 make any corresponding factual findings with a high
15 degree of confidence. I will shortly return to discuss
16 some of those incidents in the context of Harmeny's
17 acknowledgement of systemic failings and deficiencies in
18 response to abuse at the school.

19 Harmeny has also provided to the Inquiry
20 a spreadsheet containing details of a further 73
21 incidents where allegations of physical and sexual abuse
22 were made by pupils, both against staff and other
23 pupils, during the relevant period.

24 And a further spreadsheet has been provided
25 containing incidents of 'potential abuse', which it is

1 recognised the Inquiry may consider also amounted to
2 allegations of child abuse.

3 It is, of course, a matter for your Ladyship, as
4 Chair, to determine such findings as may be made about
5 the circumstances of those matters. From Harmeny's
6 perspective, however, the very fact that all of those
7 complaints or incidents have arisen needs to be
8 considered in light of the very high number of incidents
9 of physical interventions and restraint used by staff at
10 the school during the relevant period.

11 For example, the Inquiry has heard that in the year
12 2007, there were 1,217 recorded incidents of physical
13 intervention at Harmeny. And in his evidence to the
14 Inquiry, Harmeny's Chief Executive, Gavin Calder,
15 candidly and, it is submitted, correctly described this
16 figure as far too high.

17 And Harmeny have concluded that the use of restraint
18 and physical intervention on that sort of scale must
19 have created, at the very least, an increased risk of
20 children sustaining abuse and harm as a result of
21 inappropriate or unnecessary restraint procedures being
22 carried out.

23 LADY SMITH: Those figures don't exactly indicate that it
24 was being regarded as a procedure of last resort.

25 MR ROSS: I can only agree, and I think, perhaps more

1 pertinently, that is the evidence which your Ladyship
2 has from the current leadership of the school in
3 relation to that.

4 LADY SMITH: Yes.

5 MR ROSS: And the trust consider it important for me to
6 acknowledge that before your Ladyship on this occasion
7 today.

8 LADY SMITH: Yes.

9 MR ROSS: That brings us, perhaps neatly, to the issue of
10 systemic failings and deficiencies in response to abuse,
11 which is addressed at paragraphs 35 to 45 of the written
12 submission.

13 In the opening statement at the start of these
14 hearings, I said that Harmeny's overriding purpose in
15 appearing and observing the hearings was to listen to
16 and learn from the evidence, both to gain a better
17 understanding of what may have gone wrong in the past
18 and to help inform continued improvements in its current
19 practice. And I submitted that the issue of physical
20 intervention and restraint were of particular concern to
21 Harmeny in this regard, due to the particular needs and
22 vulnerabilities of the children there.

23 Having reflected on the specific issue of physical
24 intervention and restraint, Harmeny have concluded that
25 the number of such interventions was too high, as I have

1 said, and shows that physical restraint was being
2 overused at the school.

3 Harmeny considers though this may fairly be said to
4 constitute a systemic defect or failure, insofar as the
5 systems in place at the school resulted in or at least
6 did not prevent too many physical interventions from
7 being used over a number of years at the school. And it
8 is a matter of regret for Harmeny that children at the
9 school have been put at risk of harm or suffered actual
10 harm as a result of this systemic failing.

11 In the closing statement, it is also submitted that
12 the evidence led at the case study has highlighted
13 a number of instances in which Harmeny's response to
14 abuse was deficient, and these are detailed in the
15 submission at paragraphs 40 to 45.

16 Perhaps to mention one particularly troubling
17 example, the Inquiry has heard evidence about a member
18 of staff who assaulted a child by kicking them in 1997,
19 but was allowed to remain at the school with a final
20 warning, despite the demonstrated propensity for
21 violence, which created an unacceptable risk to the
22 vulnerable children at the school, and despite, too, the
23 fact that a report had been made to the Education
24 Department at the Scottish Office narrating the
25 circumstances of the incident and the disciplinary

1 response taken.

2 The staff member then carried out two further acts
3 of physical abuse against children before he was
4 eventually dismissed; both of which involved the
5 inappropriate use of physical interventions and shouting
6 at children in an angry manner, suggesting a loss of
7 self-control.

8 So Harmeny regrets that this represents both
9 a failure of its systems and a failure in its response
10 to abuse, and it recognises that children at the school
11 came to harm as a result.

12 LADY SMITH: Where in your written submission you comment,
13 Mr Ross, that the decision to keep the person in post,
14 subject to the final written warning, was 'no doubt well
15 intentioned', what are you saying?

16 MR ROSS: Your Ladyship --

17 LADY SMITH: It's in paragraph 42, six lines down.

18 MR ROSS: So the good intention was on the part of 'George',
19 who your Ladyship heard from, and he explained, in some
20 detail, his thinking behind the decision. The Inquiry
21 heard about and saw the correspondence with the
22 Scottish Office which explained his thinking, and it's
23 not submitted, of course, that it was the correct
24 decision, but it's a submission simply designed to
25 recognise that it was a decision to which anxious

1 thought was given by the responsible individual at that
2 time, and so that's what is meant by that remark. I'm
3 not --

4 LADY SMITH: But the problem was the continuing risk that
5 the man was presenting to vulnerable children, as you
6 say, Mr Ross.

7 MR ROSS: Yes, indeed. Yes, indeed, and that is why there
8 should have been an immediate dismissal.

9 LADY SMITH: Yes.

10 MR ROSS: As in fact there had been the previous year in
11 relation to a different member of staff who had
12 assaulted a child. And so there was a departure from
13 what should have happened and there's plainly no --
14 I certainly don't attempt to make any submission to the
15 contrary of that.

16 LADY SMITH: Thank you.

17 MR ROSS: It's appropriate, therefore, my Lady, having
18 reflected on the evidence led at the case study, to
19 repeat and reaffirm the apology which Harmeny offered in
20 the opening statement, and to make clear today that
21 their apology extends to the systemic failings which
22 I have just mentioned and all of the other matters
23 identified in the written submission.

24 Harmeny would like to reiterate its deep contrition
25 and regret for all shortcomings and failures on its

1 part, whether in failing to prevent incidents of abuse
2 from occurring, in its response to reports of abuse or
3 in failing to meet the high standard of professional
4 practice which is rightly expected of it.

5 To all those who have been affected by child abuse
6 at Harmeny School during this period, Harmeny would like
7 to say that it is sorry. Harmeny will try to
8 demonstrate the sincerity of these words of apology
9 through its actions in the most meaningful way it can:
10 by demonstrating its real and sustained commitment to
11 continuous improvement in its systems for safeguarding
12 of the children entrusted to its care within its current
13 therapeutic practice framework, called the Harmeny Way.

14 Turning now to the changes at Harmeny. While the
15 Inquiry's examination of Harmeny has covered the whole
16 period since its foundation in 1958, in its submissions,
17 the trust have sought to pick up the story from the
18 point where it first became responsible for the school
19 in 1995. And the trust's overall reflections in
20 relation to that period are found at paragraphs 9 to 16
21 of the written submission.

22 In my submission, the evidence led at the case study
23 establishes that when the trust took over the running of
24 the school in 1995, the original vision of the school as
25 a therapeutic community appeared to have been lost sight

1 of, or at least, as Barbara Kahan found in her review of
2 the school in 1992, the reality did not support that
3 description, and Ms Cassidy has spoken eloquently of the
4 fundamental failings identified in the school's
5 governance management and culture.

6 Changing the culture of an organisation takes time,
7 of course, and the evidence shows that all of the
8 necessary changes did not happen overnight. However, it
9 is submitted that, overall, the evidence in relation to
10 the period from 1995 onwards tells a story of continuous
11 improvement and progressive change at Harmeny, albeit
12 not without challenges, difficulties, failures and
13 shortcomings along the way.

14 The Inquiry has heard evidence from three current
15 and former chief executives which, in my submission,
16 show that the aspiration for Harmeny to exist as
17 a therapeutic community, concerned with the wellbeing of
18 the whole child, has been firstly restored and then
19 progressively realised for the children who come to live
20 at the school, such that the school today is able to
21 provide a safe, nurturing and stimulating environment
22 for the children who come to live there.

23 In particular, the evidence, in my submission, shows
24 that Harmeny has worked hard to address those problems
25 which are identified and discussed in the written

1 submission, in particular in relation to physical
2 restraint, by improvements in all the relevant aspects
3 of its systems, including staffing numbers, learning and
4 development, reflective practice and a proactive
5 strategy for further reducing physical interventions.

6 And the Inquiry has heard evidence about what
7 progress has been made on this over the years. And that
8 figure of 1,217 recorded physical interventions seen in
9 2007 had been reduced to 217 by 2024.

10 LADY SMITH: That's better.

11 MR ROSS: Indeed, it's better, my Lady, but the Inquiry's
12 examination of historical practices at Harmeny has
13 reaffirmed the importance of working to ensure that
14 physical restraint is only ever used as a last resort
15 where necessary for the safety of a child or children.
16 Apart from its legal obligations as an organisation,
17 Harmeny regards this as a central aspect of its
18 commitment to The Promise, for all care-experienced
19 children and young people in Scotland to grow up loved,
20 safe and respected, so that they can realise their full
21 potential.

22 So this is not just a historical issue, but one that
23 is of importance for Harmeny now, and, in my submission,
24 Counsel to the Inquiry was quite correct in her
25 submission to describe this as an issue of ongoing

1 concern.

2 Moreover, the disturbing events leading to the
3 recent sheriff court conviction of a former member of
4 staff of four charges of assault, apparently all
5 committed in the course of 'restraint' of children,
6 serves as a reminder that the risk to children at the
7 school from abusive conduct has not been eradicated,
8 notwithstanding the well-developed safeguarding systems
9 and measures that are now in place.

10 The main lesson for Harmeny is that safeguarding of
11 children from the risk of this or any other kind of
12 abuse must remain the single utmost priority for the
13 school.

14 In closing, and looking, if I may, very briefly, to
15 the question of improvements in future --

16 LADY SMITH: Yes.

17 MR ROSS: -- picking up on the written submissions at
18 paragraph 48 to 53, your Ladyship may recall that, in
19 his evidence, Gavin Calder described what he saw as
20 a current anomaly in the current reporting regime,
21 whereby any seclusion or restraint occurring in a care
22 setting requires to be reported to the Care
23 Inspectorate, but there is currently no equivalent
24 provision for reporting incidents which occur in
25 an education setting.

1 While Harmeny keep exactly the same records where
2 an incident occurs during care or education in the
3 classroom, there is currently no external authority to
4 which it can report in relation to the latter. Harmeny
5 consider that this amounts to a gap in the current
6 reporting arrangements and that this should be remedied
7 in some way, so that there can be equivalent requirement
8 for external reporting and monitoring of incidents of
9 restraint and seclusion occurring within education
10 systems such as is currently the position in relation to
11 care.

12 And I am sure that the Inquiry will look at this
13 question when considering recommendations in due course
14 in relation to its term of reference 7, noting, of
15 course, that it remains to be seen to what extent this
16 issue may yet be addressed by the private members' bill
17 currently proceeding in the Scottish Parliament.

18 In conclusion, my Lady, the governing mission of
19 Harmeny School today is to provide therapeutic care and
20 education to help children overcome and recover from
21 trauma and adversity, discover the joy of learning and
22 lead happy, fulfilling lives. In accordance with that
23 objective, Harmeny commits itself to ensuring that the
24 learning gained from the testimony of survivors to this
25 Inquiry, and from the report and recommendations which

1 the Inquiry will make in due course, are taken on board
2 and implemented in its approach to the care and
3 safeguarding of children at the school.

4 In conclusion of these submissions, Harmeny would
5 like to record its gratitude to all the survivors of
6 child abuse who have shown such courage in coming
7 forward to share their experiences with this Inquiry.
8 Harmeny also wishes to express once again its sorrow and
9 sympathy to all those who have been the victims of child
10 abuse at residential schools and care establishments in
11 Scotland, including at Harmeny School since it was
12 established in 1958.

13 Those are my submissions on behalf of Harmeny
14 Education Trust Limited.

15 LADY SMITH: Thank you very much, Mr Ross.

16 Well, it's now just after 1 o'clock, so I'll stop
17 now for the lunch break and sit again at 2.00.

18 Thank you.

19 (1.04 pm)

20 (The lunch break)

21 (2.00 pm)

22 LADY SMITH: Good afternoon, and welcome back to the
23 continuation of the closing submissions in Phase 9 of
24 our case study hearings.

25 I am now going to move on to another organisation,

1 the Donaldson Trust, because a section of our work
2 involved Donaldson's School for the Deaf, and I'm going
3 to invite Mr Batchelor to address me on behalf of them.

4 Thank you.

5 Closing submissions by Mr Batchelor

6 MR BATCHELOR: Thank you, my Lady.

7 On behalf of The Donaldson Trust, or Donaldson's,
8 I adopt the written closing submission which has been
9 submitted to the Inquiry. That's a document running to
10 some 18 pages. I don't intend to go through that line
11 by line, but what I would intend to do would be to go
12 through it and highlight some of the areas which
13 I consider are particularly significant.

14 LADY SMITH: Thank you.

15 MR BATCHELOR: The establishments under consideration in
16 this phase were Donaldson's School, including the junior
17 school at Henderson Row in Edinburgh, when Donaldson's
18 School was at The Playfair building at Wester Coates in
19 Edinburgh, and Donaldson's current premises in
20 Linlithgow.

21 Lynn Wassell, the current CEO of Donaldson's, and
22 Laura Watkins, who was CEO there between October 2014
23 and March 2025, and who's now a consultant with the
24 organisation, were in attendance for all of the evidence
25 relating to Donaldson's, and the Inquiry also heard

1 evidence from Ms Watkins on behalf of Donaldson's on
2 23 September 2025.

3 Donaldson's has listened carefully to the evidence
4 brought forward during this phase of the Inquiry. Some
5 of that evidence of abuse was new to Donaldson's current
6 management and was truly harrowing and shocking.
7 Donaldson's wish to thank every person who was so brave
8 in coming forward.

9 The evidence heard spanned from the 1940s to the
10 modern day and, although there were some historic
11 practices at Donaldson's which did not persist beyond
12 the earlier decades, there were elements of Donaldson's
13 institutional culture which persisted into modern times.

14 Many of the themes highlighted by Ms Innes in her
15 closing submission were seen during the evidence in
16 relation to Donaldson's. Some of those themes included
17 poor governance, leadership, attitudes to regulation
18 and, on occasion, outright denial or refusal to believe
19 that abuse existed.

20 Donaldson's acknowledged that children in their care
21 suffered abuse. Children suffered sexual, physical and
22 emotional abuse. Donaldson's wish to apologise to every
23 child who suffered abuse whilst in their care. What
24 happened to them should not have happened. Donaldson's
25 apologise unreservedly that it did.

1 Donaldson's also acknowledges that there were
2 widespread failures in their systems for safeguarding
3 children. There were also significant failures by
4 Donaldson's in its response to allegations of abuse and
5 the implementation of safeguarding procedures. There
6 were also some aspects of an institutional and
7 protectionist culture at Donaldson's which persisted at
8 least up until the late 1990s, although I would add that
9 there were also identified failures going up as late as
10 2014.

11 LADY SMITH: Yes.

12 MR BATCHELOR: For these failures, Donaldson's is also truly
13 sorry.

14 Turning to some key specific themes which arose from
15 the evidence in this case study.

16 One specific theme which has arisen and was
17 highlighted by Ms Innes is the particular vulnerability
18 of children with additional support needs and, in
19 Donaldson's case, the Inquiry may wish to give
20 particular attention to the particular vulnerabilities
21 of deaf children and how difficulties in communication
22 have increased the risk of them being abused and this
23 not coming to light.

24 One further theme related to the risk posed to
25 children by other children. From around 2000, the

1 demographic of the children at Donaldson's changed from
2 deaf pupils to include those with more complex needs.
3 The wider range of needs also gave rise to specific
4 child protection and safeguarding concerns that -- and
5 this is a quote from the preliminary notice served in
6 2014 -- the behaviour of some children and young people
7 at Donaldson's was resulting in a high number of
8 assaults of a physical, verbal and sexual nature.

9 LADY SMITH: Yes.

10 MR BATCHELOR: Briefly, my Lady, if I may just comment on
11 Donaldson's responses to the Section 21 Notices. That's
12 addressed at paragraph 9.

13 I think the key point to acknowledge here, my Lady,
14 is that when completing the response to that notice,
15 based on the records which they held, there was a gap in
16 the complaints which was found between 1950 and the
17 1990s. Donaldson's fully accept that allegations of
18 abuse were made during this period; it's simply a case
19 that they can no longer find any record in relation to
20 them.

21 There are two particularly key inspection reports
22 amongst a large number of inspection reports which the
23 Inquiry may wish to consider. In the first instance,
24 the Inquiry may wish to consider in detail the ELRIS
25 report from 1998. That report followed on a legal

1 requirement for grant-aided schools to register with the
2 local authority as residential childcare establishments,
3 and the report included 14 requirements and six
4 recommendations and was critical of a number of aspects
5 of residential care provision at the establishment at
6 the time.

7 It's a thorough report, my Lady and, in my
8 submission, the Inquiry can have confidence in making
9 findings of fact based on its findings and conclusions.
10 Donaldson's accepted the findings of the ELRIS report at
11 the time, and the former Chair of Governors,
12 John Chalmers, when giving his evidence, described the
13 report as 'the worst and best thing to happen to
14 Donaldson's'. It allowed the organisation to take stock
15 of where it was going wrong, to modernise and to
16 improve.

17 The same can also be said of the second significant
18 report, which was a joint assessment report by Education
19 Scotland and the Care Inspectorate in 2014. This report
20 was instigated after significant safeguarding concerns
21 were raised by Laura Watkins with Education Scotland.
22 The report concluded that child protection procedures in
23 place at the establishment at the time were not
24 effective in ensuring the safety of children and young
25 people, and the findings of that report resulted in the

1 service of a preliminary notice under Section 66 of the
2 Education (Scotland) Act 1980 on 14 November 2014.

3 One other helpful source of evidence is
4 documentation recovered by the Inquiry from the Scottish
5 Government which provides clarity on allegations made
6 and investigations undertaken into sexual abuse by
7 Mr PGJ in the 1980s. Those documents cast light on
8 events which were unknown to Donaldson's current
9 management. Without this evidence being obtained by the
10 Inquiry, those events would not have come to their
11 attention.

12 If I can move now to some of the applicant evidence,
13 my Lady, which is addressed at paragraphs 19 onwards in
14 the submission on page 4.

15 We heard applicant evidence in relation to the
16 junior school at Henderson Row, and if I can just pull
17 out one point in relation to that at paragraph 22,
18 my Lady.

19 My Lady will recall an account from 'Polly' of being
20 discouraged from using sign language in the 1940s and
21 early 1950s, and that account is consistent with
22 evidence contained in the book 'Silent Destiny', as is
23 the use of physical punishment, quoted as 'bordering on
24 brutality'.

25 Turning to Wester Coates. Several applicants gave

1 evidence of abusive experiences there. 'James' gave
2 particularly powerful evidence of his experiences there
3 between 1978 and 1989. His account of being groomed and
4 sexually abused by Mr PGJ between approximately
5 1979 and 1984 was harrowing. Donaldson's considered
6 that it was particularly poignant that 'James' had not
7 felt able to disclose the abuse to anyone, including the
8 police when interviewed by them, until he gave evidence
9 to the Inquiry some 45 years after the abuse started.
10 'James' also reported sexual abuse by a number of other
11 boys.

12 'Derek' also provided evidence of sexual abuse by
13 Mr PGJ, and the manipulative and threatening
14 strategies that he adopted in order to abuse boys.

15 I'll come back to Mr PGJ again shortly,
16 my Lady.

17 LADY SMITH: Yes, thank you.

18 MR BATCHELOR: I also want to say something about the
19 evidence of 'Mary'.

20 'Mary's' son was a day pupil at Donaldson's between
21 2003 and 2016. He attended at both Wester Coates and
22 Linlithgow, and Donaldson's have listened very carefully
23 to 'Mary's' account and wish to acknowledge the
24 significant distress that she experienced.

25 It's important to highlight that all allegations

1 'Mary' made to Laura Watkins in 2014 were taken very
2 seriously. They were immediately investigated by
3 an independent consultant, and 'Mary' deserves
4 significant credit that she was one of the first people
5 to bring her significant concerns to the attention of
6 Ms Watkins. That triggered immediate action that helped
7 bring about lasting changes at Donaldson's, and
8 Donaldson's wish to recognise and thank 'Mary' for this.

9 Moving on to paragraph 30, my Lady, Donaldson's also
10 want to say that 'Mary's' concerns were genuinely held,
11 and it's important to acknowledge the broad theme of her
12 evidence. That was a concern that Donaldson's were not
13 ensuring that her son was safe when in their care and
14 that the organisation wasn't following child protection
15 procedures.

16 There was also a breakdown of trust, partially due
17 to poor record-keeping practices and partially due to
18 the cultural attitudes and communication styles adopted
19 by staff towards parents at the time.

20 Donaldson's accept that 'Mary's' son was not always
21 kept safe and, for that, they are truly sorry.

22 If I can turn now to make some comments on
23 particular staff whose names appeared on several
24 occasions during the evidence, my Lady.

25 First, if I can just address the evidence of

1 David Scott.

2 LADY SMITH: Yes.

3 MR BATCHELOR: Mr Scott was principal at Donaldson's at
4 Wester Coates between 1992 and 1998, but he had also
5 previously worked there as a teacher and previously as
6 a residential care worker.

7 I don't intend to address the totality of Mr Scott's
8 evidence, my Lady, but what I would say was that
9 Mr Scott appeared to be resistant to the idea that
10 children may have been abused at Donaldson's.

11 LADY SMITH: Yes. That was quite clear.

12 MR BATCHELOR: He considered that if a child was being
13 abused, either the child or a member of staff would have
14 reported it. This suggested, in my submission,
15 a significant degree of naivety on Mr Scott's part to
16 the difficulties that children might have, and
17 particularly difficulties that deaf children may face in
18 order for them to make a disclosure that they were being
19 abused.

20 LADY SMITH: Yes, it presents as a double difficulty for the
21 children at Donaldson's. Just like all children in
22 these circumstances -- and I have heard about so many of
23 them -- they don't speak up generally, they find it
24 really, really difficult to do so, for all sorts of
25 reasons which are entirely understandable, and then in

1 the case of children who are deaf or have hearing
2 impairment, they've got the added problem of being able
3 to communicate effectively with the right person at the
4 right time, and whether it's in sign language or such
5 oral ability as they have got, it's really tough for
6 them.

7 MR BATCHELOR: Indeed.

8 LADY SMITH: It was very surprising that Mr Scott couldn't
9 see it that way. Perhaps not just naivety, but
10 an inability to empathise with the children, which might
11 have wider ramifications than that, and a lack of
12 understanding of children generally.

13 MR BATCHELOR: I would agree with those observations,
14 my Lady, and a case in point which I think illustrates
15 the difficulties is the evidence from 'James', which
16 I've already mentioned.

17 LADY SMITH: Yes.

18 MR BATCHELOR: He felt unable to report that he was being
19 abused by Mr PGJ when the police actually spoke to
20 him about it during an investigation in the 1980s.

21 Allied to what I've already said, Mr Scott also gave
22 the impression that, as principal, he was resistant to
23 outside influence and scrutiny. He did acknowledge that
24 his refusal to allow ELRIS into the school when they
25 were legally entitled to inspect it was wrong. However,

1 it is quite a remarkable position for somebody in
2 a position of responsibility to have adopted.

3 Mr Scott himself was the subject of criminal
4 proceedings. He was found not guilty in respect of six
5 out of the seven charges and was found guilty of one
6 charge of kicking a pupil. He received an absolute
7 discharge, so he had no criminal conviction.

8 We did not hear any direct evidence from applicants
9 that they were assaulted or emotionally abused by
10 Mr Scott; however, there were clearly a number of
11 allegations made against him at the time. The fact that
12 such a number of allegations were made is perhaps
13 an indication that the culture of the school and the way
14 in which Mr Scott interacted with the children was poor.
15 Mr Scott's approach was largely that all of the children
16 were liars, rather than having a more reflective
17 attitude as to why children may have been reporting the
18 very serious things that they were reporting.

19 I address the evidence in relation to
20 [REDACTED], my Lady, at paragraphs 37 to 44, but
21 I don't intend to go through that in any further detail.

22 LADY SMITH: Yes, thank you.

23 MR BATCHELOR: I'll turn to Mr [REDACTED], because I think
24 this was a very significant chapter of evidence that we
25 heard.

1 There's evidence before the Inquiry from multiple
2 sources that Mr PGJ [REDACTED], who was a former head
3 houseparent at Donaldson's, sexually abused boys in his
4 care. The Inquiry has assisted Donaldson's current
5 leadership in understanding the full nature and extent
6 of the known allegations against Mr PGJ [REDACTED], which are
7 truly shocking.

8 Evidence was heard from 'James' that he was sexually
9 abused by Mr PGJ [REDACTED] between approximately 1979 and
10 1984 or 1985. Evidence was also provided by 'Derek'
11 that he was sexually abused by Mr PGJ [REDACTED] between 1979
12 and 1981. Records recovered from the Scottish
13 Government indicate that a third pupil made allegations
14 of sexual abuse by Mr PGJ [REDACTED] to the school in 1986.
15 Those allegations were insisted upon when the boy moved
16 to another local authority. A police investigation was
17 commenced at that time and Mr PGJ [REDACTED] committed suicide
18 whilst under investigation by the police.

19 Mr PGJ [REDACTED] was a longstanding member of care staff
20 at Donaldson's. He was employed as a houseparent from
21 approximately 1964 until his death in 1986. He seemed
22 to be in some ways above suspicion from staff. There's
23 some evidence that he was a popular member of staff.
24 David Scott, in his evidence, perhaps -- charitably to
25 Mr Scott -- unaware of the full extent of allegations

1 and evidence against Mr PGJ [REDACTED], indicated that he
2 would be very surprised if he had sexually abused
3 children.

4 Documentation from the Scottish Government indicates
5 that a pupil had made a disclosure of sexual abuse by
6 Mr PGJ [REDACTED] to a teacher at Donaldson's in 1986; the
7 same pupil who subsequently reported abuse by
8 Mr PGJ [REDACTED] when he moved to a separate local authority.

9 The teacher to whom that disclosure was made brought
10 that disclosure to the attention of the principal at the
11 time. The disclosure was investigated by the principal,
12 however, no further action followed due to the lack of
13 corroboration. It does not appear that the police were
14 informed at that time.

15 And even after further serious allegations were made
16 against Mr PGJ [REDACTED], and he committed suicide whilst
17 under police investigation, the school refused to accept
18 the possibility that there was truth to the allegations.

19 Documentation from the government recovered during
20 the course of this phase also indicates that there were
21 a number of warning signs in relation to Mr PGJ [REDACTED].
22 In the early 1980s, there was an allegation of him
23 showing unsuitable videos to children. In May 1985,
24 a pupil reported seeing Mr PGJ [REDACTED] cuddling and kissing
25 another pupil. In October 1986, there were allegations

1 of Mr PGJ showing a dirty book to pupils and having
2 raunchy seaside photos in his room. We only have
3 limited information about these incidents, my Lady, but
4 it does suggest that there were certainly some missed
5 opportunities to detect Mr PGJ's abuse at
6 an earlier stage.

7 In closing this chapter, my Lady, Donaldson's
8 acknowledge and accept that Mr PGJ sexually abused
9 children at the school. There's consistent evidence
10 from multiple sources that he did so, and the Inquiry
11 can be confident in making such a finding, in my
12 submission.

13 The written submission goes on to address the nature
14 and extent of abuse, my Lady, covering historic
15 practices, abuse by staff, restraint, isolation and peer
16 abuse. I don't intend to go through that in any more
17 detail in my oral submission. There is a detailed
18 response in relation to all of those themes in the
19 Part B and Part D responses which have been provided to
20 the Inquiry.

21 LADY SMITH: Thank you.

22 MR BATCHELOR: If I can move on now to themes from the
23 evidence, my Lady, some of which we've already covered.

24 Donaldson's acknowledge that the systems in place
25 failed to protect children. Systemic themes identified

1 prior to hearing any evidence included recruitment of
2 staff and recruitment processes, staff training and
3 experience, monitoring and supervision of staff,
4 guidance and instruction, complaints procedures and
5 response to complaints, inspections, escalations of
6 concerns, record-keeping and culture. In the interests
7 of time, my Lady, I don't intend to go through each of
8 those themes, but I would like to just highlight some of
9 the themes which arose through the evidence.

10 The first is the suitability of the building, and
11 I'm thinking particularly here of Wester Coates.
12 Evidence was heard from several witnesses that that
13 building in some ways contributed to the risk of abuse
14 occurring. Whilst obviously an architecturally
15 impressive building, it became unsuitable for deaf
16 education, and John Chalmers, the former Chair of the
17 Board of Governors, gave very clear evidence about it
18 being an institutional building which had been built
19 really in another era. 'Mary', a former pupil, gave
20 evidence of it being possible to spy on girls in the
21 changing room, and 'Tim' also gave evidence that it was
22 easy to find places within the vast building where there
23 was no supervision. Although attempts at modernisation
24 were made to the building, the lack of suitability of
25 the building did not resolve until Donaldson's moved to

1 Linlithgow in 2008.

2 Another clear theme which arose, my Lady, related to
3 complaints and investigations. Investigations into
4 complaints of abuse were not thorough or carried out in
5 a way which gave children the best opportunity to make
6 a disclosure. The evidence suggests that applies to
7 external investigations by social work and the police,
8 as well as by Donaldson's, and examples of this are
9 given at paragraphs 66 to 70. And if I can just take
10 three examples of those, my Lady.

11 The first is the principal's investigations into the
12 various incidents involving Mr PGJ. The precise
13 nature of those investigations is not clear from the
14 documentation that we have. However, for investigations
15 into very serious allegations, they appear to have been
16 perfunctory. The principal also does not appear to have
17 considered it appropriate to refer the allegations to
18 a third party to investigate or to inform the local
19 authority or police when a disclosure was made to the
20 teacher at the school.

21 Susanne Goetzold was a social worker who gave
22 evidence of an investigation that she was involved in
23 around 1998 where a child disclosed abuse by
24 David Scott. That has clearly stuck with her for a long
25 time. She acknowledged in her evidence that the

1 interview techniques that were being employed at that
2 time were not ideal. She had not been formally trained
3 at that time. But she also gave evidence of the police
4 carrying out what they termed 'a retraction interview',
5 at which the child was invited to withdraw her
6 allegations.

7 She also highlighted, my Lady, another difficulty,
8 because that child was deaf, with the translation and
9 communication, and how things that were being translated
10 from what the child was saying were not necessarily
11 being said in the way that she would have said them.
12 And clearly that increases the risk of misunderstandings
13 and potentially also inconsistencies in how things are
14 reported, even though the child may have been consistent
15 throughout.

16 LADY SMITH: Yes.

17 MR BATCHELOR: The police investigated an allegation of rape
18 of a pupil by the principal in around 1994. We heard
19 evidence about that from Mr Scott, who recalled this
20 investigation by the police. The Board of Governors do
21 not appear to have been informed of this allegation and,
22 as the police elected to take no further action,
23 Mr Scott did not consider that any further action was
24 required. That would clearly have been a decision
25 better made by others.

1 If I can turn now, my Lady, to culture. It's clear
2 that historically Donaldson's had institutional
3 practices. There was, however, evidence that some of
4 the institutional aspects of the establishment persisted
5 for far longer than they might have been expected to.
6 In particular, there were some striking pieces of
7 evidence that a closed culture was operating at
8 Donaldson's at least up until the late 1990s.

9 One stark example of that which I have already
10 alluded to is, at the time of the ELRIS inspection,
11 following the Children (Scotland) Act, as I've
12 mentioned, grant-aided schools, the residential units
13 there became subject to registration requirements and
14 subject to local authority inspections. And when trying
15 to fulfil their statutory function, the ELRIS inspectors
16 encountered stiff resistance from Mr Scott when trying
17 to inspect Donaldson's in 1997/1998.

18 Mr Scott's evidence on that matter was quite
19 remarkable. He expressed a dislike of social workers.
20 However, that also presented as an aversion to outside
21 scrutiny. Given the damning report issued by ELRIS
22 following Mr Scott's suspension and subsequent
23 departure, the Inquiry may wish to consider whether
24 Mr Scott had other reasons to be resistant to external
25 scrutiny.

1 At the time of the police investigation in 1998,
2 when Mr Scott, Mr KNJ and Mr KNK had been
3 suspended, other senior staff members signed a letter of
4 support for them. This was at a time when a number of
5 children who were pupils at the school had made
6 allegations of abuse, some of which resulted in criminal
7 charges. The Inquiry may consider that this indicated
8 a culture where children were not listened to, heard or
9 believed.

10 The Scottish Government documentation recovered for
11 this phase indicate that allegations of sexual abuse by
12 Mr PGJ were made to the school in 1986. The school
13 do not appear to have informed the police at that time.
14 The police only subsequently became involved following
15 the intervention of a local authority. The principal's
16 approach to the allegations demonstrates a closed
17 mindset that abuse might be happening right under his
18 nose. Even following Mr PGJ's suicide, the school
19 and the Board of Governors appear to have refused to
20 accept the possibility that one of their trusted members
21 of staff may have been abusing children.

22 By way of some more recent examples, my Lady, in
23 2002, a pupil at the school made a disclosure that she
24 had been raped by 'Tim'. The Inquiry had the benefit of
25 some detailed paperwork around the thought process of

1 those involved, and whilst detailed consideration
2 appears to have been given to the question of whether or
3 not, despite the pupil's wishes, the authorities should
4 be informed and the decision on that reached in good
5 faith, it's difficult to understand why no advice was
6 sought from external agencies as to the appropriate way
7 in which to proceed. This could easily have been done
8 on a no-names basis while still protecting the child's
9 confidentiality. Once the Care Inspectorate became
10 aware of the position, they were highly critical of the
11 decision not to have informed them at an earlier stage,
12 and they were right to be so critical.

13 In 2010, there was another example of advice not
14 being sought from external agencies and what action
15 might be required. This followed an allegation made
16 against PWV in respect of an incident which had occurred
17 at a staff member's birthday party in their home. The
18 allegation was that PWV had sexually assaulted that
19 staff member's 16-year-old son.

20 And although the precise reasons why action was not
21 taken at the time are not entirely clear and there are
22 starkly differing versions of events, the upshot was
23 that no action was taken by anyone at Donaldson's until
24 2013. Once again, no advice appears to have been taken
25 externally, although PWV did consult his trade union on

1 what he should do.

2 It's clear that numerous members of staff were aware
3 of this incident, or at least aware of rumours, yet
4 nobody took action to formally report it. Donaldson's,
5 as an organisation, failed to report it. By not taking
6 action at the time, children at Donaldson's were exposed
7 unnecessarily to the risk of abuse between the time of
8 the incident and PWV's eventual suspension in 2013.

9 The Inquiry may also wish to consider, my Lady,
10 whether difficult relationships between members of the
11 senior management team themselves, as well as the
12 principal's relationship with the staff and the Board of
13 Governors, gave rise to a dysfunctional culture forming
14 at Donaldson's at that time.

15 LADY SMITH: Yes.

16 MR BATCHELOR: Turning to the governors, my Lady, another
17 significant theme which has some relation to the culture
18 of the organisation relates to governance and
19 specifically the skill set of the board and how the
20 Board of Governors exercised oversight of the school,
21 two themes highlighted by Ms Innes in her closing
22 submission.

23 Evidence was heard from John Chalmers about how he
24 first became involved with the Board of Governors, and
25 that was on the basis that he was minister of the local

1 parish church. The evidence gave the impression that,
2 certainly until the 21st century, the Board of Governors
3 was a group of well-meaning individuals who didn't fully
4 appreciate the responsibility that they had, including
5 the critical role that they should play to ensure that
6 children at the school were kept safe. They were not
7 integrated into the school environment and activities
8 and were not exercising proper oversight.

9 That lack of integration was also evident in 2014.
10 The joint inspection report found that the Board of
11 Governors were not providing adequate support and
12 governance to the school. The board did not routinely
13 monitor, review or quality assure the work of the
14 school.

15 And evidence was heard from Mary Mulligan, who was
16 Chair of the Board of Governors from 2012 to 2014. Her
17 evidence in some respects, my Lady, was rather vague,
18 and she didn't seem to understand the responsibilities
19 in leading an independent school. She felt like the
20 Board of Governors needed help, but didn't seem to fully
21 appreciate that it was the role of the Board of
22 Governors to identify what help they needed and to go
23 out and find it.

24 LADY SMITH: It was quite striking. It was as if she
25 thought that the state or the local authority should

1 step in and volunteer help, but, as you rightly say,
2 this was an independent school and most independent
3 schools would reel at the thought that the state would
4 just step in to say, 'We think that you need some help
5 when you haven't asked'.

6 MR BATCHELOR: I agree, my Lady. It was a striking piece of
7 evidence.

8 LADY SMITH: Yes. It wasn't something that she seemed
9 naturally suited to do, if I can put it that way.

10 MR BATCHELOR: If I can move on, my Lady, now to a section
11 on improvements and reflection.

12 Donaldson's recognise the failings of the past and
13 are truly sorry. Donaldson's wish to acknowledge the
14 deep harm and lifelong impact suffered by those who were
15 abused in their care. The Inquiry has served to
16 reinforce and strengthen Donaldson's commitment to keep
17 safe children and young people and support them within
18 a culture that ensures their voices are always heard.

19 After the Section 66 preliminary notice was served
20 in 2014, the new leadership team at Donaldson's took
21 immediate steps to address the concerns raised. This
22 involved a root-and-branch review of all policies,
23 systems and processes. Donaldson's undertook a full
24 governance and policy review to ensure that safeguarding
25 of children was and is their number 1 priority and is

1 embedded at every level of the organisation.

2 That process of improvement is a continuous one,
3 my Lady, and Donaldson's worked closely with Education
4 Scotland and the Scottish Government and, in 2018, the
5 preliminary notice was removed, some four years after it
6 was put in place.

7 LADY SMITH: Yes, thank you.

8 MR BATCHELOR: Donaldson's single biggest priority is child
9 and adult protection, my Lady. Donaldson's recognise
10 that this starts with the organisation's fundamental
11 culture and leadership, including Donaldson's values and
12 behaviours. During the Inquiry, Donaldson's have
13 learned a great deal from their past about what can
14 happen without the right culture and leadership,
15 underpinned by clear accountabilities, robust training,
16 systems, policies and processes.

17 Donaldson's culture and practices in relation to
18 safeguarding are supported by a safeguarding framework.
19 This includes a designated executive safeguarding lead
20 and supporting safeguard staff, together, this group is
21 critical in identifying patterns, learning and
22 introducing improvements on a continuous cycle;
23 a safeguarding steering group that holistically oversees
24 all systems, processes and reporting; a trustee with
25 safeguarding practice experience who supports

1 Donaldson's with government oversight and constructive
2 challenge; and key policies and procedures and training
3 programmes relating to safeguarding child and adult
4 protection, including working with statutory bodies and
5 other agencies.

6 Donaldson's today provides a school and other
7 services to support children and young adults outwith
8 mainstream education. Donaldson's has three children
9 who are deaf or hearing impaired and use British Sign
10 Language, with support from staff trained in British
11 Sign Language and a deaf practitioner and speech
12 therapist. Other children and young adults have a range
13 of different needs. Each person's needs are
14 individually assessed, monitored and met. Every child
15 has a risk assessment in place.

16 Donaldson's learned from the Inquiry about the
17 historic challenges for children in confidence,
18 communication and feeling isolated. Donaldson's has
19 individual plans for everyone and measures how their
20 confidence and skills are growing, including support for
21 socialisation.

22 Donaldson's are engaging with modern technology and
23 use tools such as communication boards, symbols,
24 visuals, talking mats, communication passports and
25 visual timetables. They keep up to date with good

1 practice and learn and experiment with what works best
2 for the children and young adults that they support.

3 Donaldson's final reflection, my Lady, from its
4 involvement with the Inquiry is that it is imperative
5 that safeguarding is at the heart of what any
6 organisation caring for or educating children does.
7 That was not the case for Donaldson's in the past.

8 As I've said, Donaldson's have learned much from the
9 Inquiry, and the management team there now understand
10 a lot more about its evolution, social history and where
11 it's failed. Donaldson's wishes to reconfirm its
12 unwavering commitment to the safety of the children and
13 young people they support. They will not always get
14 everything right and they will learn from it when they
15 do not, as they've learned from the Inquiry. Openness,
16 transparency and continuous improvement in learning will
17 remain embedded in Donaldson's culture.

18 Donaldson's thank the survivors whose courage has
19 helped them face the past honestly. They will endeavour
20 to honour that courage by ensuring that Donaldson's is
21 a place of safety, care and trust.

22 Thank you, my Lady.

23 LADY SMITH: Thank you very much, Mr Batchelor.

24 I'd like to turn next, please, to the representation
25 for Sight Scotland, and I think that's you,

1 Ms Loosemore; is that right?

2 Closing submissions by Ms Loosemore

3 MS LOOSEMORE: Yes, thank you, my Lady.

4 Sight Scotland wishes to begin this closing
5 submission by saying that it has been a very powerful
6 experience for those from the organisation who have been
7 involved with the Inquiry to read the documentary
8 evidence and, most significantly, to see the witnesses
9 who had the courage to give oral evidence to the
10 Inquiry. Sight Scotland is grateful for the work of the
11 Inquiry and in particular grateful to the individuals
12 who have come forward to share their experiences.

13 And I do want to adopt my written submissions.
14 I won't read them out in their entirety, my Lady.

15 Ross Murray, Head of Governance and Impact and
16 Charity Secretary, and Lucy Chetty, Head of Education
17 Services, gave evidence on behalf of Sight Scotland and
18 were present for the rest of the evidence on that day.
19 They were also joined by Pam Gaiter, who's the Executive
20 Support Manager. Members from the organisation attended
21 again on 27 August to hear further evidence and, indeed,
22 Mr Murray is present for today's proceedings.

23 Each of those individuals was profoundly moved by
24 the experience. It is one thing to know intellectually
25 that abuse has been suffered by some people at some time

1 in the past, but it's quite another to see and hear
2 directly from the affected individuals.

3 The process of the Inquiry has actually uncovered
4 certain chapters in the school's history that the
5 current leadership team had been unaware of, and it is
6 one of the benefits of the Inquiry that it can bring
7 together information from multiple sources and create
8 a much fuller picture of the institutional history than
9 Sight Scotland was able to do on its own. And that is
10 reflected in information which has come to light since
11 Sight Scotland submitted its original Section 21
12 Response, and the organisation has now submitted
13 an addendum that incorporates that new information
14 that's come to light.

15 And I wish to make clear at the outset that
16 Sight Scotland does not dispute the accounts of abuse of
17 the former students that this Inquiry has heard.
18 Indeed, many of their accounts have been proven in
19 criminal courts. Sight Scotland is deeply saddened by
20 the crimes that have come to light and wishes to express
21 its heartfelt sorrow to the pupils who were the victims
22 of any abuse while at the Royal Blind School.

23 And my Lady, in the written submission, there is
24 then a brief history of the school set out in
25 paragraph 5, which I won't go through orally.

1 LADY SMITH: Yes, thank you.

2 MS LOOSEMORE: So turning then to the evidence of abuse at
3 the Royal Blind School.

4 Sight Scotland does not intend to make detailed
5 submissions with respect to the abuse suffered by the
6 former students of the Royal Blind School, other than to
7 say that no issue is taken with their accounts of what
8 happened.

9 Now, my Lady, I do pause here to make a brief
10 comment in respect of the evidence of David Penman.
11 It's obviously a matter for your Ladyship. I suppose,
12 on one view, he's given evidence both in relation to
13 potentially being the victim of certain forms of abuse
14 and also as somebody who is a convicted abuser, so it
15 will be a matter for your Ladyship as to how much of his
16 evidence to accept, but I do point out that he is
17 a witness who denies committing offences that have
18 obviously been proven to the criminal standard, and I'm
19 sure your Ladyship will approach his evidence with the
20 appropriate caution.

21 LADY SMITH: Thank you.

22 MS LOOSEMORE: The balance of what I would like to address
23 in the submissions is focused on the school's role in
24 terms of prevention and response to the accounts of
25 abuse by the former students.

1 And I'll address these matters first in terms of
2 staff, and perhaps more significantly, I think, for the
3 Royal Blind School, the abuse by fellow pupils.

4 With respect to abuse by staff members, it's
5 submitted that the evidence before the Inquiry does not
6 identify a significant, widespread pattern of physical,
7 emotional or sexual abuse of students by staff. The
8 Inquiry has obviously heard about two former staff
9 members who've been specifically identified as abusers,
10 and I appreciate there was some evidence also from
11 'Diana' and 'Angie' with respect to certain -- certainly
12 humiliating and degrading behaviours on the part of
13 staff.

14 I make that submission not to diminish, obviously,
15 the seriousness of the abuse that did happen, but simply
16 to try and delineate the scope of abuse that we're
17 talking about.

18 I think with respect to abuse by staff members, the
19 Inquiry may find that the Frank McGeachie case was the
20 most serious. That abuse occurred between 1986 and
21 1988, and seems to have been brought to the attention of
22 the school in 1988.

23 At that point, from what we can gather from the
24 somewhat limited documentation available, it appears
25 that the school did deal swiftly and appropriately with

1 the matter. Your Ladyship has seen the correspondence
2 between the school and the Scottish Education
3 Department, which indicates that the school suspended
4 Mr McGeachie when the allegations first came to light,
5 and conducted an internal inquiry that resulted in his
6 dismissal and ultimately charges by the police, of which
7 he was convicted.

8 And in the aftermath of what had happened with
9 Mr McGeachie, the school again did engage with the
10 Scottish Education Department to review and revise their
11 procedures with a view to preventing such abuse from
12 happening again. It's somewhat difficult, my Lady, to
13 assess the quality of those new procedures based on the
14 documentation we have --

15 LADY SMITH: Yes.

16 MS LOOSEMORE: -- because we can't really put it in the
17 context of whatever else may have been in place at the
18 time. But what can be said is that there have not been
19 substantial allegations of abuse by staff since 1988.

20 And my Lady, currently, all the care staff are
21 registered with the Scottish Social Services Council.
22 They have the relevant qualifications. They report to
23 the residential care manager, and there's an additional
24 team of registered nurses who also report to the
25 residential care manager.

1 The school is confident that the current recruiting
2 practices, qualification and experience requirements,
3 and vetting procedures, mean that all care staff are
4 appropriately qualified to work in a residential care
5 setting with vulnerable, high-needs young people.
6 Safeguarding is a significant focus of the current
7 recruitment process.

8 LADY SMITH: And of course, checking qualifications and
9 seeing that somebody is appropriately qualified is but
10 the beginning.

11 MS LOOSEMORE: Yes, absolutely, my Lady.

12 LADY SMITH: And the organisation's systems of supervision
13 and monitoring and training then have to be strongly in
14 place to keep protecting children against abuse.

15 MS LOOSEMORE: Yes, that is absolutely true, my Lady, and at
16 the end of the submission, there's a list of some of the
17 current procedures that are in place to do exactly that.

18 LADY SMITH: Thank you.

19 MS LOOSEMORE: If I can turn then to the peer-to-peer abuse.

20 The Inquiry may find that it is that type of abuse
21 that has historically been the most problematic at the
22 Royal Blind School, and what Sight Scotland wishes to
23 say at the outset of this section is that they
24 acknowledge that there were clearly failures on the part
25 of staff to take seriously and address appropriately

1 matters of this nature that were brought to their
2 attention by students.

3 For example, a number of troubling incidents seem to
4 have been categorised or dismissed really as horseplay
5 or a prank or were met with a kind of 'boys will be
6 boys' attitude. This resulted in some matters not being
7 dealt with as early as they could have been, and it
8 resulted in highly inappropriate responses, including
9 victim blaming, once matters were brought to the
10 attention of the school leadership.

11 The evidence before the Inquiry makes clear that the
12 students who were victims of these assaults were left
13 feeling disbelieved and unsupported by the school, and
14 for that, Sight Scotland offers an unreserved apology.

15 Now, there are three cases in particular that the
16 Inquiry has heard about which each resulted in criminal
17 convictions against former students, and those are
18 David Penman, Christopher Smyth, and PWU .

19 With respect to David Penman, he was convicted of
20 committing a number of offences related to eight
21 different fellow students while at the Royal Blind
22 School. The offence dates range from 1987 to 1991, at
23 a time when David Penman would have been between about
24 12 and 16 years old.

25 Now, a police investigation was not initiated until

1 2013, and it does appear that, at that stage, the school
2 co-operated with police. This Inquiry has statements
3 and has heard oral evidence from two of the former
4 students who were among those targeted by David Penman,
5 and clearly his criminal convictions indicate that the
6 scope of the abuse was significantly wider than that.

7 Coming into the Inquiry, the current leadership team
8 at Sight Scotland had believed that the school didn't
9 know anything about what had happened with David Penman
10 at the time he was a student. However, they acknowledge
11 that, having seen the statements of the former students
12 that were taken as part of this process, as well as the
13 documents recovered by the Inquiry related to the 2013
14 criminal investigation, quite a different picture
15 emerges from those documents.

16 From Alison Thomson's, who was then the vice
17 principal -- from her statements to police in 2013, she,
18 it must be said somewhat reluctantly, acknowledges that
19 she had been told that David Penman was engaged in
20 inappropriate sexual behaviour with at least one other
21 student.

22 'Diana' says that she regularly told staff how
23 uncomfortable Mr Penman made her feel. Your Ladyship
24 may recall that 'Angie' describes how she was summoned
25 to Alison Thomson's office and told that she might be

1 suspended because of an incident involving Mr Penman and
2 another male student coming into the girls' dormitory
3 one night. When 'Diana' explained to Ms Thomson that,
4 in fact, it was Mr Penman who had assaulted her,
5 Ms Thomson simply didn't believe her, and Mr Penman
6 appears to have stayed at the school for some years
7 after that incident.

8 There's no formal record that there was any risk
9 assessments or really any comprehensive investigation by
10 the school, nor, I think crucially, any involvement by
11 a third-party agency, such as the police or social work,
12 when staff, including Ms Thomson, were advised of
13 Mr Penman's abuse. And in fact, it appears that
14 Ms Thomson continued to blame 'Angie' and to protect and
15 defend Mr Penman.

16 The current leadership team at Sight Scotland are
17 appalled by this approach. Sight Scotland accepts that
18 once any abusive incidents had been brought to the
19 school's attention, there should have been a much more
20 robust institutional response, and that such
21 an appropriate response may well have prevented
22 Mr Penman's abusive behaviour from continuing.

23 My Lady, I'll leave the Christopher Smyth matter to
24 the written submissions. Paragraphs 18 and 19 --

25 LADY SMITH: Yes, I've seen that, thank you, yes.

1 MS LOOSEMORE: -- detail that situation.

2 And if I can then turn to PWU [REDACTED].

3 With respect to PWU [REDACTED], the incident
4 reports which your Ladyship has seen from the school
5 detail several concerns -- quite a number of concerns,
6 really -- that were raised between [REDACTED] 2001 and
7 [REDACTED] 2002, and then the incident for which
8 Mr PWU [REDACTED] was ultimately convicted occurred on
9 [REDACTED] 2002.

10 Now, when that incident was brought to the school's
11 attention, it does appear that appropriate child
12 protection procedures were followed in terms of
13 reporting the matter to social work and then ultimately
14 to the police. However, Sight Scotland recognises
15 significant deficiencies in how the matter was handled.
16 And in particular, it's reported that Ms Thomson made
17 a highly inappropriate and insensitive remark to the
18 victim's father, along the lines of, 'Isn't this
19 something all boys do at this age?', when she was
20 engaging with him.

21 The Inquiry has a statement and heard the oral
22 evidence from 'Cosmo', who is the victim of that
23 assault, and even with that series of previous incidents
24 which school staff were aware of, Mr PWU [REDACTED] was able
25 to invite 'Cosmo' to his room and commit a very serious

1 criminal offence without any staff intervention.
2 Sight Scotland acknowledges that this indicates
3 a serious breakdown in their child protection
4 procedures.

5 While there were some policies and systems in place
6 at that time in the school, they were not adhered to
7 properly. This may suggest a failure of the leadership
8 to create an environment where such abuse would be taken
9 seriously and would not be tolerated. And I think
10 that's borne out by Ms Thomson's handling of matters.

11 Sight Scotland does wish to note that the school
12 engaged with the Care Commission in the aftermath of
13 what happened with PWU [REDACTED] to update their
14 child protection policy. However, obviously, that came
15 too late to protect 'Cosmo'. The Inquiry has heard from
16 him just how devastating an impact the assault by
17 Mr PWU [REDACTED] had on his life.

18 My Lady, there are some other more -- well, I don't
19 want to say minor issues, but less fully detailed in the
20 evidence issues, that are addressed in the written
21 submission at paragraph 23, and I'll just leave those to
22 the written submissions.

23 But if the Inquiry takes all of the matters
24 involving the peer-to-peer abuse together, what the
25 Inquiry may find is that, historically, there has been

1 a serial problem with peer-to-peer sexual abuse at the
2 Royal Blind School, and Sight Scotland accepts that
3 there was a failure on the part of the school to take
4 seriously early reports of troubling behaviours by the
5 students who were ultimately convicted of sexual
6 offences against their fellow students.

7 Sight Scotland recognises that there were missed
8 opportunities to proactively deal with matters through
9 a child protection lens. Had appropriate steps been
10 taken, for example proper risk assessments of the
11 students involved, or earlier referrals to outside
12 agencies, some of the harm caused to former students of
13 the school could have been avoided and, for that,
14 Sight Scotland is deeply regretful.

15 So, by way of conclusion, my Lady, there have been
16 significant changes to the Royal Blind School since the
17 early 2000s, and some of these structural changes mean
18 that the opportunity for peer-to-peer abuse has been
19 significantly lessened.

20 The student population is currently much smaller and
21 tends to be comprised of young people with complex needs
22 that cannot be managed in a mainstream school setting,
23 and that's really a result of the mainstreaming policy
24 that I believe was maybe around 2005 that that started.
25 So the school at the moment has ten residential pupils

1 and each of them has their own private room.

2 Each student has a social worker and educational
3 psychologist, who have typically supported the referral
4 and admission process to the school. The school very
5 much embraces a multi-agency approach to supporting its
6 young people, which means that the support system for
7 each student is far more robust than it used to be. And
8 this approach has a preventative effect. The school is
9 confident, for example, that the way David Penman's
10 behaviour was addressed by his expulsion from the school
11 without any involvement of any third-party agencies
12 would not occur today.

13 And there are now many processes, both formal and
14 informal, which work together to ensure that all pupils
15 at the school are kept safe from harm. There is a list
16 of some of those processes and procedures in
17 paragraph 26 of the written submission.

18 But notwithstanding these changes and improvements,
19 it is right and proper to acknowledge the past. What
20 happened is part of the history of the school and it is
21 important that it not be forgotten, so that we can
22 remain vigilant in the present. Child welfare,
23 including child protection, must always be at the heart
24 of any residential educational institution.

25 Sight Scotland cannot change what happened in the

1 past, but it is committed to doing everything in its
2 power to prevent anything like this from occurring in
3 the future at the Royal Blind School.

4 Thank you, my Lady.

5 LADY SMITH: Thank you.

6 And Ms Loosemore, I should probably put on record
7 that we do have, thank you, the addendum to
8 Sight Scotland's Section 21 response that has been
9 provided, and that's very helpful.

10 MS LOOSEMORE: Yes, thank you.

11 LADY SMITH: And it's plain that it fits with what is now
12 being acknowledged in your submissions this afternoon.

13 I would now like, please, to turn to the
14 Lord Advocate, Ms Lawrie.

15 Closing submissions by Ms Lawrie

16 MS LAWRIE: My Lady, I'm grateful for this opportunity to
17 make a closing submission on behalf of the
18 Lord Advocate.

19 As with previous closing submissions, this one is
20 brief, as it is understood that the focus of the present
21 case study is not, at this time, on the Crown, although
22 that will, of course, change during the anticipated
23 criminal justice case study.

24 During this phase, the Inquiry has heard evidence of
25 the physical, sexual and psychological abuse of children

1 within residential establishments for children and young
2 people with long-term healthcare needs, additional
3 support needs and disabilities.

4 Evidence has been provided that some of this abuse
5 was reported to and thereafter investigated by the Crown
6 Office and Procurator Fiscal Service, which I will
7 shorten to COPFS. Indeed, the Inquiry has heard
8 evidence that prosecutorial action was subsequently
9 taken in respect of several individuals against whom
10 allegations of abuse were made, and some of that
11 evidence has come from individuals who are also
12 complainers to prosecutions and from individuals who are
13 relatives of complainers.

14 It's acknowledged, my Lady, that some of these
15 individuals were critical of their experience of the
16 criminal justice system and, in particular, of
17 interacting with COPFS. Some of that evidence ties in
18 with themes of criticism which have emerged in previous
19 case studies and which centre around failures in
20 communication.

21 The Lord Advocate recognises that, in addition to
22 firm commitments to use Inquiry evidence to improve the
23 service delivered to survivors of institutional abuse,
24 of greater interest will be the concrete steps which are
25 being taken by the organisation to try to give effect to

1 that improvement.

2 In terms of how COPFS is seeking to improve the
3 information provided to survivors of abuse, the
4 Lord Advocate wishes to draw attention to the revised
5 and updated information available on the COPFS website
6 for adult survivors of institutional child abuse. This
7 section of the website seeks to provide relevant
8 information in an accessible manner, signpost survivors
9 to appropriate services and provide an insight into what
10 can be expected should a case be reported to COPFS, all
11 with the aim of supporting engagement with the justice
12 system.

13 LADY SMITH: And I see that there's also a link to our
14 website. I think it's in the section that explains to
15 people that it may not be possible to prosecute in every
16 case.

17 MS LAWRIE: Indeed, my Lady.

18 Key to the review of this part of the website was
19 the involvement of those with lived experience of
20 institutional child abuse. The views of members of the
21 survivors' group Voices for a Better Future were sought
22 on the previous website content. That feedback helped
23 develop the updated content, which was approved by the
24 COPFS Abuse in Institutions Board and published on the
25 website in April 2025. COPFS is very grateful to the

1 survivors, whose participation in this process was vital
2 to informing the review.

3 In conclusion, my Lady, may I repeat the
4 Lord Advocate's ongoing commitment to supporting the
5 work of the Inquiry and to contributing both positively
6 and constructively to its work, and also to ensuring the
7 fair, effective, rigorous prosecution of crime in the
8 public interest for all members of society, including
9 the most vulnerable.

10 I'm grateful, my Lady.

11 LADY SMITH: Thank you, Ms Lawrie.

12 Could I now turn, please, to the representation for
13 Police Scotland. I think that's you, Ms Whyte.

14 Closing submissions by Ms Whyte

15 MS WHYTE: My Lady, I'm grateful for the opportunity to make
16 this closing submission on behalf of the Chief Constable
17 of the Police Service of Scotland.

18 Firstly, the Chief Constable wishes to express
19 sympathy to all survivors of childhood abuse, including
20 survivors who have experienced abuse within any of the
21 17 establishments featured within this case study.

22 The Chief Constable would also like to take this
23 opportunity to reassure survivors, the Inquiry and the
24 people of Scotland that Police Scotland is fully
25 committed to thoroughly investigating all forms of child

1 abuse that have taken place in Scotland, regardless of
2 when it happened or who was involved.

3 Police Scotland remains committed to delivering its
4 response to the Inquiry and ensuring that all relevant
5 information held is provided in compliance with the
6 terms of the notices issued under the Inquiries Act
7 2005. This information includes policies, procedures
8 and documents relating to investigations into the abuse
9 and neglect of children within the establishments
10 featured within this case study.

11 Police Scotland also wishes to inform the Inquiry
12 that, in keeping with its continued commitment to
13 non-recent child abuse investigations, it is currently
14 investigating non-recent abuse within establishments
15 featured within this phase of the Inquiry. These
16 investigations have arisen out of both the review of
17 previous investigations and new reports of abuse from
18 survivors.

19 Police Scotland continues to build on its engagement
20 with survivors of childhood abuse, seeking views and
21 consulting with survivors, support services and
22 statutory partners to enhance public confidence and
23 improve service provision.

24 Police Scotland recognises the importance of using
25 organisational learning to effect continuous improvement

1 to ensure its staff have the best skills and
2 capabilities to deal with the specific needs of
3 survivors of child abuse. As such, Police Scotland will
4 take into account any good practice or areas of learning
5 that may be identified from this phase of the Inquiry's
6 hearings as part of its commitment to developing and
7 improving its service provision.

8 Finally, Police Scotland remains committed to child
9 protection, both locally as a core statutory child
10 protection agency, and nationally in partnership with
11 multi-agency and strategic leadership groups to
12 implement continuous improvements and make a positive
13 contribution to protecting Scotland's children, both now
14 and in the future.

15 LADY SMITH: Thank you very much.

16 Well, that's now 3 o'clock. I will stop for a short
17 mid-afternoon break to give everybody a breather, and
18 after the break I will turn to the Care Inspectorate and
19 hear from Ms Toner.

20 Thank you.

21 (3.02 pm)

22 (A short break)

23 (3.12 pm)

24 LADY SMITH: Now, as I trailed before the break, I'm going
25 to move to the Care Inspectorate next, and that takes me

1 to Ms Toner. Whenever you're ready, thank you.

2 Closing submissions by Ms Toner

3 MS TONER: Good afternoon, my Lady, and thank you.

4 My Lady, on behalf of the Care Inspectorate, may
5 I place on record at the outset, as has indeed been
6 acknowledged in previous submissions, the recognition of
7 the courage of those who have given evidence in this
8 phase of the Inquiry's work. They have given the most
9 difficult evidence on the most difficult of experiences,
10 and their bravery in so doing, my Lady, is to be
11 commended.

12 My Lady, I have lodged a written submission with the
13 Inquiry which I would seek to formally adopt, and it
14 would not be my intention, my Lady, to rehearse what's
15 contained within that submission, but rather to
16 highlight the key themes which have emerged from the
17 evidence in this phase from the perspective of the
18 Inspectorate in relation to the work that it does.

19 My Lady, the written submissions have focused
20 predominantly on the evidence which was given by
21 Charlotte Wilson, the Chief Inspector for Children and
22 Young People's Services within the Care Inspectorate,
23 both in her oral evidence which was given to the Inquiry
24 on 15 May of this year, and in the regulation report to
25 which she spoke in evidence and through which she was

1 taken by Counsel to the Inquiry. I understand, my Lady,
2 that a later phase of the Inquiry will explore
3 regulation more specifically.

4 I would, however, in the meantime invite your
5 Ladyship to find that the evidence of Ms Wilson has been
6 valuable to the Inquiry, as regards the approach taken
7 by the Inspectorate as to the conduct of its inspections
8 today and as regards what I would submit is the clear
9 recognition on the part of the Care Inspectorate that
10 the child should be front and centre of that whole
11 process.

12 My Lady, the four themes which have been focused in
13 written submissions are, first, the Inspectorate's
14 approach to inspections; secondly, restraint and
15 restrictive practices; thirdly, accessibility to the
16 Inspectorate for children and young people; and, lastly,
17 proposed policy and legislative changes.

18 Dealing with these in turn, my Lady, in terms of the
19 approach to inspections, whereas inspectors in the past
20 had what might be described as a generic caseload, there
21 is now a dedicated team for children and young people's
22 services. That team includes eight inspectors whose
23 specific remit is the inspection of residential special
24 schools. My Lady, with the dedicated team has come
25 a dedicated focus on the needs of children and young

1 people and, in my submission, my Lady, it will have been
2 clear from the evidence of Charlotte Wilson that the
3 Inspectorate considers that communication is key in
4 order to get the most from an inspection, and that's
5 both from the point of view, my Lady, of the inspector,
6 but more importantly, my Lady, from the point of view of
7 children and young people using a service.

8 And the importance, my Lady, of communication has,
9 of course, particular application in this phase of the
10 Inquiry, which is focused on children for whom
11 communication may have been more challenging, as your
12 Ladyship has, in fact, remarked upon this afternoon.

13 Charlotte Wilson spoke of an approach now of total
14 communication, which, as it sounds, is an approach
15 recognising that not one size fits all, and that
16 different communication methods need to be used to
17 communicate appropriately and usefully with a child or
18 young person with additional support needs. And she
19 spoke of the importance of early engagement with
20 a service prior to an inspection to ingather as much
21 information as possible about a service and those in its
22 care, including the ways in which children and young
23 people with additional needs may communicate. Further,
24 my Lady, she spoke of the variety of communication tools
25 which inspectors now have training in and which they use

1 in order to best communicate with a child, depending on
2 that child's needs.

3 In relation to restraint and restrictive practices,
4 this is a subject upon which the Inquiry has heard much
5 evidence.

6 LADY SMITH: Yes.

7 MS TONER: And it is recognised, my Lady, that thinking in
8 that area has moved on significantly since the creation
9 of the Care Commission in 2002.

10 Now, my Lady, in the course of an inspection, and
11 indeed at service registration stage, the Inspectorate
12 would want to see a service's restrictive practice
13 policy. It would also expect to see individual risk
14 assessments on inspection, as well as verification that
15 staff have suitable training in restraint reduction.
16 And where any incident of restraint or restriction
17 occurs in a care setting, a full report requires to be
18 recorded and the Inspectorate notified.

19 As has been referenced in the written submission, my
20 Lady, clearer guidance has now been produced as regards
21 reporting expectations in relation to restrictive
22 practices and it is hoped, my Lady, that the
23 Inspectorate's work in this area of practice will go
24 some way to providing increased clarity on the use of
25 restraint and restrictive practices to those engaged in

1 the delivery of residential care to children and young
2 people, all of course, my Lady, with the aim of
3 improving the experience of children and young people in
4 these services.

5 LADY SMITH: If the expectation of notification to the
6 Inspectorate is adhered to, the Inspectorate could be in
7 the position of building up a valuable database across
8 the board, which would help all children in any such
9 establishment, anywhere in Scotland.

10 MS TONER: Indeed so.

11 My Lady, moving on, if I may, to the question of
12 accessibility to the Inspectorate.

13 The Inspectorate recognises the value in a child
14 being able to raise concerns directly with it, and it
15 has taken steps to enhance accessibility for children to
16 make complaints or raise concerns direct. It has
17 developed its digital systems to essentially minimise
18 the formality in raising a concern. Concerns can now be
19 raised direct with the Inspectorate by text, phone,
20 email or through its website and, as is outlined in the
21 written submission, my Lady, an animation explaining the
22 modes of raising concerns direct is shared with the
23 service for its users. I understand, my Lady, that
24 further digital work is underway to further enhance
25 accessibility, including current consideration of the

1 development of an app for that purpose.

2 My Lady, in terms of proposed legislative change,
3 the written submissions on behalf of the Inspectorate
4 set out its engagement with the Scottish Government on
5 those matters and it is committed to contributing what
6 it can to that process, and it will continue to do so.

7 My Lady, as is emphasised in the written
8 submissions, the Inspectorate recognises the importance
9 of a person-centred approach to its inspections and the
10 importance of using methods of communication which are
11 suitable to young service users, and it is hoped that,
12 in so doing, it can get the most from its inspection
13 process, all of which, my Lady, is for the good of the
14 children and young people in receipt of care.

15 Lastly, my Lady, may I offer assurance to the
16 Inquiry that the Inspectorate is committed to assisting
17 the Inquiry in its work, to listening to the evidence,
18 and to learning from this process. And should the
19 Inquiry identify any improvements or changes which the
20 Inspectorate can make to any aspects of its work, these
21 will be acted upon. Equally, my Lady, where any changes
22 or improvements to the services it regulates are deemed
23 necessary, it will encourage and, if necessary, my Lady,
24 enforce those.

25 LADY SMITH: Thank you very much.

1 MS TONER: Thank you, my Lady.

2 LADY SMITH: Thank you, Ms Toner.

3 Finally, Ms O'Neill for Scottish Ministers. When
4 you're ready.

5 Closing submissions by Ms O'Neill

6 MS O'NEILL: Thank you, my Lady.

7 Your Ladyship will be aware that there is a very
8 lengthy written submission for the Scottish Ministers
9 submitted to the Inquiry, which I adopt in full, but
10 which I will attempt to address orally in
11 a proportionate way.

12 LADY SMITH: Thank you.

13 MS O'NEILL: The written submissions address the evidence
14 heard by the Inquiry from applicants during this phase
15 of the Inquiry's work. Those written submissions also
16 seek to address certain wider themes that have featured
17 in that evidence, and the submissions also attempt to
18 update the Inquiry on matters that concern the Scottish
19 Ministers' wider responsibilities for the regulatory
20 framework within which the relevant services are
21 delivered.

22 From paragraph 6 to 11 of the written submission,
23 I deal with the Scottish Ministers' interest in Phase 9,
24 and your Ladyship's familiar with that.

25 At paragraph 12 onwards, I wish to acknowledge the

1 evidence given by applicants as to the abuse suffered by
2 them in the relevant establishments. As is said at
3 paragraph 14, Scottish Ministers would wish applicants
4 to understand that representatives of the Scottish
5 Government have listened to their evidence and continue
6 to listen to the evidence given by applicants. The
7 Scottish Government accepts and believes the evidence
8 that has been given about the abuse that has been
9 experienced, some of which evidence is described later
10 in the submissions. And as in earlier stages of the
11 Inquiry, the Scottish Government acknowledges the
12 courage of all the individuals who gave evidence about
13 their experience and about the impact of childhood abuse
14 on their future lives, and records its gratitude to them
15 for contributing to the Inquiry.

16 The next part of the submission deals with apology,
17 and the Scottish Government wishes to reiterate the
18 apologies already given on behalf of Education Scotland
19 in relation to this phase of the Inquiry's work. In the
20 written report submitted to the Inquiry in March of this
21 year, Education Scotland apologised to children and
22 their families for failings in inspection regimes that
23 contributed to the creation of environments that enabled
24 the abuse of children to take place in the
25 establishments that are the subject of this case study.

1 And when giving evidence on behalf of Education
2 Scotland in May, His Majesty's Interim Chief Inspector
3 of Education for Scotland, Janie McManus, repeated the
4 acknowledgements contained in that report. Ms McManus
5 said that it was unacceptable that any child was abused
6 or subjected to abusive practices, conditions and
7 regimes, and that children attending educational
8 establishments should have done so with the expectation
9 that they would be safe and free from harm.

10 She went on to say that, and I quote:

11 'On behalf of Education Scotland, the agency
12 currently responsible for the inspection of education,
13 I would like to apologise sincerely for failings in
14 inspection regimes over the years which have contributed
15 to environments that enabled the abuse of children to
16 take place. I would like to apologise to each of those
17 children and their families for the harm and distress
18 caused at the time of the abuse and the effect that this
19 has had on their lives. In my capacity as His Majesty's
20 Interim Chief Inspector of Education, I want to ensure
21 that the inspection of education is trusted by children
22 and that it helps in protecting them and keeping them
23 safe from harm.'

24 And my Lady, in my opening statement for this phase,
25 I also made clear that the Scottish Government

1 anticipated that the Inquiry would hear evidence
2 pointing to failings in relation to legislation, policy
3 and resourcing as contributing to an environment that
4 allowed abuse to take place, and that it would not
5 hesitate to acknowledge and apologise for such failings.

6 There are various matters dealt with in the written
7 submissions in respect of which I offer an apology on
8 behalf of Scottish Government and its predecessors, and
9 Education Scotland and its predecessors.

10 My Lady, the written submissions include reference
11 to various examples of abuse heard by the Inquiry. That
12 is not intended to repeat evidence that the Inquiry has
13 heard or usurp, indeed, the role of Inquiry Counsel, but
14 it is to contextualise the apologies that are given and
15 to make it clear that those apologies are given on the
16 understanding of the evidence that has been heard.

17 LADY SMITH: Thank you.

18 MS O'NEILL: My Lady, the first theme is lack of respect,
19 and the Inquiry has heard evidence about historical
20 inspection reports and government records in which, on
21 occasion, inspectors and other officials make comments
22 about children and families that, on any view,
23 demonstrate lack of respect and in some cases contempt
24 and a lack of care on the part of those involved. Some
25 of that language has already been referred to today.

1 LADY SMITH: Yes.

2 MS O'NEILL: I refer to it because it was made by inspectors
3 and, therefore, my client is responsible for that
4 language.

5 Ms McManus, when she gave evidence, acknowledged
6 that the views expressed by HM Inspectors were
7 unacceptable. The Scottish Government acknowledges the
8 distress and anger that would be rightly felt by any of
9 those about whom those comments were made. They are
10 evidence of attitudes that the Scottish Government
11 disowns and for which it apologises. It endorses
12 Ms McManus's response to you, my Lady, that all children
13 should receive an education that is suitable to their
14 needs and enables them to make progress.

15 LADY SMITH: And should not be regarded as lesser children
16 just because they have particular needs and they're not
17 as easy to educate, for example, as some other children.

18 MS O'NEILL: Indeed so, my Lady, and I can only emphasise
19 that that is the Scottish Government's position.

20 My Lady, the next chapter is in relation to lack of
21 response, and the Inquiry has heard substantial evidence
22 of reports and complaints of abuse being made to police,
23 to social workers, staff, children's hearings and
24 others, but which resulted in no action being taken.

25 At paragraph 24, I note that children were often too

1 afraid to report abuse, knowing that they would not be
2 believed. Some were unable to report abuse due to
3 communication difficulties; for example, children who
4 were deaf and not permitted to use sign language.

5 At paragraph 25, I note that witnesses gave evidence
6 that they did not report abuse because they had no one
7 to turn to due to a lack of external oversight,
8 monitoring or investigation.

9 At paragraph 26, I note that police routinely
10 returned children to establishments without questioning
11 them or following up on allegations of abuse and, in my
12 submission, the starkest example of that is of the pupil
13 who absconded more than ten times from Corsbie Hall in
14 1972 and who ultimately died on his 13th attempt and,
15 despite the circumstances, there was little
16 investigation by the relevant authorities and the school
17 was not held accountable.

18 At paragraph 27, I note that reports to family
19 members had mixed outcomes in terms of belief of the
20 child and action then being taken when parents attempted
21 to raise these issues with schools.

22 Ultimately, many children did not complain about
23 abuse because they were not listened to, not believed or
24 saw no changes when they did speak up. As a result,
25 many applicants described a profound and lasting loss of

1 trust in authority figures, most notably the police.

2 From paragraph 29 onwards, I describe what I say is
3 a range of factors that were at play in creating that
4 culture, and I won't address those individually, but at
5 paragraph 34, what is said is that there were failings
6 by a range of institutions and organisations across the
7 whole period with which the Inquiry is concerned and in
8 relation to which it has heard evidence.

9 However, it is clear that, in addition, for failings
10 for which Scottish Government or its predecessors were
11 directly responsible, particularly in relation to
12 inspection, which is dealt with later in the
13 submissions, the state failed to take steps by way of
14 legislation, policy, oversight and resource to create
15 effective routes for the reporting and responding to
16 abuse.

17 My Lady, in each of these chapters, I attempt to
18 address the current situation.

19 So far as current practice is concerned, and in
20 relation to whistleblowing, the Scottish Government's
21 national child protection guidance makes clear that
22 organisations which work with children and young people
23 should have policies in place that allow individuals to
24 escalate a child protection concern outside of their
25 management structure.

1 And I quote from that guidance:

2 'In healthcare settings, the National Whistleblowing
3 Standards apply across NHS Scotland and are overseen by
4 the Independent National Whistleblowing Officer.
5 Concerns can be raised locally where appropriate, and if
6 staff have already raised concerns locally or do not
7 feel able to do so, they can contact Healthcare
8 Improvement Scotland about concerns relating to the
9 safety and quality of patient care.

10 'In the context of residential care, the Scottish
11 Social Services Council's codes of practice encourage
12 care establishments to have whistleblowing policies in
13 place, and the SSSC and Care Inspectorate have created
14 joint guidance on raising concerns in the workplace.'

15 At paragraph 38, I note that in relation to
16 children, the Scottish Public Services Ombudsman has
17 published child-friendly complaints-handling principles
18 and child-friendly complaints-handling process guidance
19 which outlines how public service organisations in
20 Scotland, including mental health services, should
21 handle complaints from or involving children and young
22 people in a way that respects their rights and supports
23 their participation. The guidance aims to ensure that
24 children with additional support needs are fully
25 included in the complaints process, and recognises that

1 some children may need tailored communication methods,
2 more time or support to understand and express their
3 views.

4 In residential care settings, children should be
5 made aware of the organisations' complaints policies and
6 have access to advocacy services to help them raise
7 concerns and guidance specifies the records that have to
8 be kept, and compliance with that will be assessed by
9 the Care Inspectorate.

10 In education settings, there's no requirement to
11 notify HM Inspectors of Education about complaints and
12 HM Inspectors do not investigate complaints as such, but
13 do review schools' arrangements for ensuring child
14 protection and safeguarding. And the new Education
15 (Scotland) Act 2025, which I address in more detail
16 later, also provides that, in the exercise of the Chief
17 Inspector's functions, the Chief Inspector must have
18 regard to the need for relevant establishments to have
19 adequate arrangements in place to safeguard and promote
20 the welfare of children and young people, which duty is
21 broad enough to encompass the adequacy of complaints
22 mechanisms.

23 My Lady, there's then reference to HM Inspectors and
24 Education Scotland.

25 My Lady, I move on to inspection practices, and

1 acknowledge that the Inquiry has heard evidence about
2 failures in inspection practice. Those failures include
3 the absence of any inspection activity whatsoever, or
4 long and unexplained gaps between inspections.

5 Applicants have given evidence that they simply did
6 not see any inspectors during the time they were
7 accommodated in the establishments under review, and
8 former members of staff have given evidence to similar
9 effect.

10 The Inquiry has had evidence from Education Scotland
11 that the historical records indicate that a contributing
12 factor to failures to undertake inspection activity was
13 lack of clarity about the role of HM Inspectors in
14 inspecting the provision of education in healthcare
15 settings.

16 The Inquiry explored with Ms McManus a number of
17 examples which demonstrated poor practice by inspectors,
18 including failures to take appropriate action in
19 response to evidence that indicated that children had
20 suffered abuse or might be at risk, and I make mention
21 of a number of examples.

22 There was evidence in relation to Donaldson's School
23 of an inspector asserting strongly his own view that
24 there was no substance in allegations of sexual abuse at
25 the school and, separately, of an inspector failing to

1 have regard to Scottish Education Department guidance
2 that corporal punishment should not be used in relation
3 to children with disabilities.

4 At paragraph 48, the submission acknowledges, and
5 the Scottish Government acknowledges, and apologises
6 for, this poor practice. It has made earlier
7 submissions to the Inquiry that inspection activity is
8 not principally focused on the detection of abuse, and
9 the Inquiry's framework document for Phase 8
10 acknowledges that inspection alone would not be
11 a sufficient safeguard against abuse. However, the
12 government accepts without reservation that failures in
13 inspection contributed to a regime in which abuse was
14 able to occur and to continue.

15 And for the avoidance of doubt, it also accepts
16 without reservation the point that was made by your
17 Ladyship to Ms McManus; that it's not for HM
18 Inspectorate of Education to say, 'Allegations of sexual
19 abuse aren't something we take anything to do with
20 because we are just looking at education'; if a child is
21 being abused, you have to proceed on the basis that it
22 is likely to have an adverse effect on their ability to
23 be educated. Ms McManus immediately accepted that point
24 in her evidence and it is uncontroversial.

25 LADY SMITH: Thank you.

1 MS O'NEILL: Further, if there is evidence of a child being
2 abused, it is for the Inspectorate to respond
3 appropriately to that, not simply because it may have
4 an adverse effect on education, but for the more
5 fundamental reason that all and every step should be
6 taken to combat such abuse.

7 While accepting that there is always a risk of poor
8 practice occurring and that complacency must be avoided,
9 the Scottish Government would ask the Inquiry to have
10 regard to the clear evidence given by Ms McManus about
11 the different approach that would be taken today in
12 response to the various matters raised with her about
13 past inspection practice. It would ask the Inquiry also
14 to have regard to the totality of the evidence provided
15 by Education Scotland about the current inspection
16 regime and plans for reform.

17 My Lady, there's a short section in the written
18 submission on Donaldson's School. The submissions do
19 not generally pick up on each establishment, but the
20 written submission responds to evidence about the period
21 between 2014 and 2018. It is a point that your Ladyship
22 I think explored with Mr Batchelor earlier, and it's in
23 relation to the evidence of Ms Mulligan and the extent
24 to which the Scottish Government had provided support to
25 Donaldson's School.

1 I don't propose to take your Ladyship through the
2 detail of that in the written submission. There is one
3 technical point that I would simply mention, and that is
4 the reference to Donaldson's as an independent school.
5 I think I am bound to say that it is a grant-aided
6 school, but clearly has much greater independence and
7 autonomy in terms of its governance than a local
8 authority school would have.

9 LADY SMITH: I appreciate, so far as being able to survive
10 financially is concerned, Donaldson's can't do it
11 without the government grants that come in, but when it
12 comes to governance decisions and the running of the
13 school, that's for them to do.

14 MS O'NEILL: And that, my Lady, is of the essence of the
15 submission that's in the written submission, but
16 I simply make the point just because of the reference to
17 independence.

18 LADY SMITH: Yes. It just seemed unfortunate that
19 Ms Mulligan plainly felt a bit at sea at one stage and
20 had this instinctive feeling that surely the state in
21 some form should be sweeping in and helping them.

22 MS O'NEILL: And, my Lady, again, lest there be any doubt,
23 I think Scottish Government has accepted in earlier
24 phases of this Inquiry, that it, of course, has
25 responsibility for the overarching regulatory framework

1 within which all of these institutions operate and
2 I wouldn't demur from that.

3 LADY SMITH: Absolutely.

4 MS O'NEILL: But day-to-day management is a different issue.

5 LADY SMITH: Definitely not, and not sailing in and saying,
6 'When's your next governors' meeting? We need to have
7 some people there and find out what you're doing and
8 tell you how to do it'.

9 MS O'NEILL: Yes.

10 My Lady, the next chapter of the submission is in
11 relation to reform of the education inspection regime,
12 and there are two matters dealt with specifically in the
13 written submission.

14 The first of those is what is now the Education
15 (Scotland) Act 2025. The Inquiry heard submissions from
16 me while this bill was going through its passage in the
17 Scottish Parliament.

18 LADY SMITH: Yes.

19 MS O'NEILL: It was passed by the parliament on 25 June. It
20 received royal assent on 6 August and the Inquiry's
21 already heard evidence about the reasons for
22 introduction of that legislation.

23 My Lady, paragraphs 61 onwards, in essence,
24 summarise the key provisions of the legislation. I'm
25 certain that everyone here would enjoy me reading all of

1 those out on a Friday afternoon, but I will resist the
2 temptation.

3 LADY SMITH: You're going to disappoint us?

4 MS O'NEILL: I will resist the temptation, my Lady, and
5 I will simply commend those paragraphs to the Inquiry.

6 LADY SMITH: Very well.

7 MS O'NEILL: But what I would draw your Ladyship's attention
8 to is paragraph 67, which is the current state of
9 implementation of the legislation.

10 LADY SMITH: Yes.

11 MS O'NEILL: On 2 October, the Cabinet Secretary for
12 Education and Skills gave an update to the Scottish
13 Parliament by way of a response to a written question on
14 the current anticipated timetable for commencement and
15 for implementation of the new inspection body, which
16 will be His Majesty's Inspectorate of Education. She
17 explained that, from 1 November, HMIe will begin phased
18 establishment, pending the making of an order under the
19 Scotland Act 1998 by the UK Parliament, which is
20 expected by the end of the year. And during this time,
21 HMIe will operate increasingly independently, with a new
22 website and business support functions, and will begin
23 to develop and establish its advisory council.

24 LADY SMITH: What am I to take from your use of that
25 expression, 'phased establishment'? In practical terms,

1 what are you pointing to?

2 MS O'NEILL: I think, my Lady, HMIe will not have the

3 statutory powers to begin its work -- or the statutory

4 powers governing its work will not be in force until the

5 relevant order is made by the UK Parliament, but steps

6 are being taken meantime in order to set up the

7 organisation, if I can put it in blunt terms like that.

8 LADY SMITH: So it will be good to go?

9 MS O'NEILL: That's the intention. That's the intention, my

10 Lady.

11 LADY SMITH: Thank you.

12 MS O'NEILL: A substantive appointment to the role of

13 His Majesty's Chief Inspector of Education in Scotland

14 is also anticipated in that period. My Lady, that's on

15 the legislative side.

16 Your Ladyship may recall that Ms McManus gave

17 evidence that she had initiated a review of the current

18 school inspection framework and inspection methodology

19 to address various aspects of the school inspection

20 process, including the current framework, 'How good is

21 our school?', fourth edition.

22 Paragraphs 69 to 73 explain the progress of that

23 review programme and I would simply, I think, point

24 particularly to paragraph 73, which explains that,

25 alongside various other consultation exercises,

1 HM Inspectors will engage and have engaged with children
2 and young people. HM Inspectors invited all local
3 authorities to nominate primary and secondary aged
4 pupils to meet with HM Inspectors during October 2025 to
5 ensure that their voices and views are an integral part
6 of any revisions to school inspections, and there will
7 also be a specific programme of engagement for children
8 with additional needs and, in particular, those in
9 special schools with severe and complex needs to ensure
10 that their views are also captured.

11 And, my Lady, that reference to October 2025 is
12 obviously to this month. That engagement has been
13 ongoing in this month.

14 LADY SMITH: Thank you.

15 MS O'NEILL: There is a separate chapter, my Lady, on the
16 issue of integrated inspections. And at paragraph 75,
17 I make the overarching submission that inspection
18 regimes have become more integrated over time, with the
19 Care Inspectorate carrying out joint inspections with
20 Education Scotland and undertaking shared inspections of
21 those schools and services where both care and education
22 are provided, including those undertaken in response to
23 risk and that was spoken to by Janie McManus in her
24 evidence.

25 Paragraph 76 summarises some elements of the legal

1 and regulatory framework.

2 Paragraph 77 refers to the Independent Review of
3 Inspection, Scrutiny and Regulation, in respect of which
4 the Inquiry has had earlier evidence.

5 At paragraph 78, I note that, in January of this
6 year, a new quality improvement framework for inspection
7 of early learning childcare, child minders and
8 school-aged childcare providers was published. That was
9 developed by His Majesty's Inspectors of Education and
10 the Care Inspectorate in collaboration with the sector
11 and is a new shared inspection framework for the early
12 learning and childcare sector. Both HM Inspectors of
13 Education and the Care Inspectorate undertook extensive
14 engagement on the framework and piloted use of that
15 framework in a number of settings, together and
16 separately, and, my Lady, that began to come into use
17 in September of 2025.

18 There is then, my Lady, a chapter on healthcare
19 establishments, and a number of themes are dealt with
20 under that heading. The first is healthcare services
21 and inspection.

22 My Lady, I don't mean to duplicate evidence from
23 Healthcare Improvement Scotland on that issue. I do
24 summarise, at paragraph 82, the framework around
25 Healthcare Improvement Scotland and, at paragraph 83,

1 the framework around the Mental Welfare Commission for
2 Scotland.

3 I note at paragraphs 84 and 85 the fact that
4 long-term residential hospitals for children and young
5 people with mental health needs, neurodivergence or
6 learning disability no longer exist in Scotland, but
7 that there are three regional adolescent mental health
8 in-patient units for young people and, of course, my
9 Lady, those were the subject of the Disclosure Scotland
10 programme --

11 LADY SMITH: The Disclosure Scotland documentary.

12 MS O'NEILL: -- and your Ladyship has had the evidence on
13 where matters stand with that.

14 So far as the healthcare needs of children in
15 schools are concerned, the Scottish Government has
16 published guidance on that matter and that's referred to
17 at paragraph 86.

18 And then in relation to the education needs of
19 children in healthcare settings, I do note at
20 paragraph 87, and it's been said before, that legal
21 responsibility for the provision of education to
22 children in healthcare establishments does not rest
23 directly with Scottish Ministers, but Scottish
24 Government has produced guidance in relation to the
25 legislative and policy context, and giving advice on the

1 roles and responsibilities of local authorities,
2 hospitals and other services in relation to children
3 unable to attend school due to ill-health. The current
4 guidance was published in 2015, and that's described in
5 the following paragraphs, but I note at paragraph 90
6 that the guidance is to be refreshed in the course of
7 next year.

8 There are duties under the Education (Scotland) Act
9 1980 for local authorities to make provision for
10 children and young people who are unable to be educated
11 at what might be described as a traditional educational
12 establishment. They do not apply to schools in the
13 independent sector, and if a child or young person
14 registered with an independent school is likely to be
15 absent from school for a prolonged period, the school
16 should make arrangements directly with the family to
17 consider how they continue to support education for as
18 long as the child remains absent from school due to
19 ill-health.

20 Healthcare establishments may be inspected by
21 HM Inspectors of Education under Section 66 of the
22 Education (Scotland) Act 1980 if they are registered as
23 a school or if they are providing education as
24 a peripatetic service. So, for example, Education
25 Scotland has recently carried out an inspection of the

1 Hospital Education Service in Glasgow, which comprises
2 the Royal Hospital for Children in Glasgow and
3 Stobhill School, which is otherwise known as Skye House,
4 the report of which will be published in due course.

5 LADY SMITH: Yes.

6 MS O'NEILL: My Lady, the next chapter concerns restraint,
7 and the use of restraint was obviously a key issue in
8 Phase 8 and continues to be a key theme in Phase 9.

9 Many applicants gave evidence about the
10 inappropriate violent and abusive use of constraint
11 which occurred across the decades and across
12 establishments and included abusive practices in
13 relatively recent times. The applicant evidence on that
14 issue was supplemented by the material in the Education
15 Scotland report to which Janie McManus spoke. Excessive
16 use of restraint is obviously also a key issue around
17 the allegations made about Skye House.

18 I say at paragraph 96 that, as it was the case in
19 relation to establishments considered in the last case
20 study, a number of factors contributed to environments
21 in which abusive restraint practices were able to
22 develop and be used. Those included the absence of
23 policies in relation to restraint, the absence of
24 training or the provision of inappropriate training.

25 The Scottish Government apologises for the omissions

1 of central government, including in relation to the
2 absence of adequate legislative and policy regimes and
3 the absence of requirements for training that
4 contributed to an environment in which these practices
5 were used and treated as being acceptable.

6 My Lady, I note that submissions were made at the
7 end of Phase 8 on the statutory provisions and guidance
8 on restraint in secure accommodation, and clearly that's
9 not repeated here.

10 The opening submissions for this phase referred to
11 the Restraint and Seclusion in Schools (Scotland) Bill,
12 which was introduced in the parliament in March by
13 Daniel Johnson MSP. And at the time of opening
14 submissions, the government was considering the detail
15 of the bill, which is focused on restraint and seclusion
16 in education settings.

17 The Scottish Government has since responded to the
18 Education, Children and Young People Committee's call
19 for views, and the memorandum on the government's
20 position on the bill has been published on the Scottish
21 Parliament's website.

22 The Scottish Government supports the general
23 principles of the bill but may propose amendments to the
24 bill in due course on matters of detail. The response
25 notes that there is some, but not complete, overlap

1 between the bill's provisions and existing powers in
2 relation to the proposed duty to record and report on
3 the use of restraint and seclusion contained in the
4 bill. There is alignment between the bill's provisions
5 and key aspects of the Scottish Government's 2024
6 guidance on physical intervention in schools.

7 The broad definition of 'restraint' contained in the
8 bill could risk defining as restraint practices that are
9 not of obvious concern and so the government considers
10 that there's merit in exploring whether an and/or
11 definition of 'restraint' would achieve the key aims of
12 the bill.

13 The bill proposes that certain persons and groups
14 should be consulted about guidance to be made under the
15 bill in connection with restraint and seclusion, and the
16 government's view is that consideration should be given
17 to including children and young people in the list of
18 consultees, and that there are potential inconsistencies
19 in the bill in relation to national reporting on the use
20 of restraint and seclusion as between education
21 authorities on the one hand and independent and
22 grant-aided schools on the other.

23 The bill remains at stage 1, my Lady, and the
24 stage 1 report of the committee is anticipated to be
25 delivered by January of next year.

1 LADY SMITH: This is a very difficult subject, and recalling
2 Charlotte Wilson explaining to us that it's not been
3 a simple journey, with a history of two or three
4 different ways of restraining -- if that's the right way
5 to put it -- children, and having reached a general view
6 about the way to do it; far from it, because I can't
7 remember the exact number, but I was astonished at her
8 evidence regarding the exact number of techniques that
9 could be in play at the moment and accepted even in
10 different parts of the country as entirely appropriate.

11 That's not to say any of them are wrong, but it does
12 show that we probably have some way to go before we can
13 reach a consensus of what, in most cases, is the best
14 way to address the problem, looking at it through the
15 eyes of the children, and what's the best thing for
16 them.

17 MS O'NEILL: And clearly, my Lady, it remains a live
18 legislative question, at present.

19 My Lady, I do make reference to the evidence of
20 Charlotte Wilson in the next paragraphs of the
21 submission. That's in connection with the question of
22 reporting --

23 LADY SMITH: Yes.

24 MS O'NEILL: -- of restraint, and, my Lady, the position is
25 that there is a protocol in place at present, and has

1 been since May of this year, for the reporting of all
2 incidents of restraint and restrictive practices that
3 occur in secure accommodation services, whether in
4 education or in care. But it is accepted, my Lady, that
5 there is no general obligation to report incidences of
6 restraint in an education context outside of secure
7 care. But, my Lady, I make the point that that is
8 a matter that may be addressed by the bill that is
9 currently before parliament. There is some material
10 also, my Lady, on holding safely, which is the guidance
11 in place in relation to restraint.

12 My Lady, there is a sub-chapter on sedation and
13 chemical restraint, to which Ms Innes made reference
14 earlier in her submissions. I simply say at
15 paragraph 113 that the practices described by applicants
16 were unacceptable. The Scottish Government is
17 responsible for the failures of its predecessors to put
18 in place legislative policy and practical measures that
19 would have helped to ensure that such practices did not
20 occur. The Scottish Government apologises for those
21 failures. It acknowledges that they had a direct and
22 serious impact on children to whom the state had moral
23 and legal responsibilities.

24 And then, my Lady, there is some discussion of the
25 current legal regime relating to the use of medication

1 without an individual's consent.

2 LADY SMITH: Yes.

3 MS O'NEILL: My Lady, there is a main chapter of the
4 submission on isolation and seclusion, which begins at
5 paragraph 118, acknowledging that abusive practices in
6 relation to isolation and seclusion also featured in the
7 evidence of many applicants and was supported by the
8 evidence of former members of staff and by documentary
9 evidence spoken to by current senior NHS officials.
10 There is a description of much of that evidence, my
11 Lady, which I will not repeat.

12 I simply draw the Inquiry's attention to
13 paragraph 124, where it's said that the Scottish
14 Government accepts its role and the role of its
15 predecessors in allowing that freedom of action, that is
16 the freedom of action that was given to individual
17 institutions and members of staff, and apologises to
18 those who suffered abuse as a result.

19 And my Lady, conscious of the time, I do wish to
20 focus on those areas of the submission where
21 acknowledgement and apology is made, so that that is on
22 the record for those affected.

23 LADY SMITH: Certainly. Thank you.

24 MS O'NEILL: My Lady, the next chapter is peer-on-peer abuse
25 and unwanted sexual behaviour.

1 And again, these submissions acknowledge that the
2 Inquiry has received substantial evidence from
3 applicants about peer-on-peer abuse, including physical,
4 emotional and sexual abuse and bullying. Conditions
5 that allowed that abuse to take place included placing
6 children in adult wards in hospitals and where lack of
7 supervision allowed sexual and physical assaults by
8 patients on other patients to become commonplace,
9 including abuse of children by adults. Education
10 Scotland's report refers to various occasions on which
11 Education Scotland and its predecessors were aware of
12 peer-on-peer abuse in Phase 9 establishments.

13 At paragraph 130, I note that the inadequacies of
14 Scottish Government's records relating to Phase 9
15 establishments make it difficult to assess accurately
16 the response of the relevant authorities, but it is
17 accepted by Scottish Government that in very many cases
18 the response was wholly inadequate, and it apologises
19 for those failures.

20 There is, my Lady, then some reference to cases in
21 which I would submit responses were appropriate to some
22 extent, and I will leave those for the Inquiry to
23 consider.

24 There is a chapter on suicide and self-harm. The
25 Inquiry has heard evidence from many applicants who

1 described engaging in self-harming behaviour while
2 accommodated in the establishments under review,
3 including attempted suicide. And I make reference to
4 the appalling example of an applicant giving evidence
5 that their own key worker had raped them and then cut
6 their arms so as to give the appearance of self-harm,
7 and obviously the BBC's documentary on Skye House also
8 included allegations of self-harm going unnoticed by
9 staff members. I refer to applicant evidence about
10 their mental health difficulties, including depression
11 and PTSD in adult life because of the neglect and abuse
12 experienced in residential care.

13 The Scottish Government apologises to all the
14 children who suffered in this way for the systemic and
15 regulatory failures that contributed to an environment
16 in which children felt compelled to self-harm and were
17 not properly cared for when they did so.

18 The Scottish Government also acknowledges that
19 self-harm and suicide among children and young people in
20 care environments continues to occur and requires
21 ongoing and sustained action to address it.

22 And my Lady, the steps that are being taken by
23 Scottish Government in this field are important. They
24 are described at paragraph 138 onwards. I am very
25 conscious, my Lady, of the time, and I don't want to

1 read those out, but by not doing so, I do not want to
2 give any impression that there is any lack of emphasis
3 on the response to suicide and self-harm.

4 LADY SMITH: Yes.

5 MS O'NEILL: From paragraph 140 onwards, the submission
6 deals with failure to provide education. As in earlier
7 case studies, the Inquiry has heard evidence that
8 children were failed in the establishments under review
9 in relation to the provision of education. Again, as in
10 earlier case studies, children and young people in these
11 establishments were underestimated and their education
12 was not treated seriously. And in this case study,
13 those failures were exacerbated by practices that
14 exploited the disabilities of children and were
15 themselves inappropriate and abusive.

16 And I make reference to the evidence given by pupils
17 at St Vincent's in particular in relation to attempts to
18 cure deaf pupils, the description of which was clearly
19 of abusive practices and practices involving forcing
20 children to learn to lip read.

21 At paragraph 145, the Scottish Government
22 acknowledges that it was the responsibility of the state
23 to ensure that appropriate education was provided for
24 every child accommodated in these establishments and
25 that the delivery of that education should have

1 responded to the particular needs of the children
2 concerned. At the very least, the children should not
3 have felt they were being punished because they had
4 a disability, and the Scottish Government apologises to
5 all of those children affected by these failures,
6 recognising the deep and lasting impact that they have
7 had.

8 My Lady, there is then a chapter on GIRFEC, 'Getting
9 it right for every child' that responds, in part to
10 evidence that was given by Dr MacIntyre, Dr Stewart and
11 Professor Kendrick on the extent to which GIRFEC
12 responds appropriately to disabled children.

13 At paragraph 149, the Scottish Government notes and
14 accepts that the critiques of GIRFEC from the
15 perspective of those with disabilities has largely
16 focused on the lack of participation of children and
17 families in the process of creating plans and designing
18 relevant interventions.

19 The Scottish Government is aware of inconsistencies
20 in the implementation of GIRFEC for children and young
21 people with a disability and are working with local
22 authorities, health boards and third-sector
23 organisations to ensure the specific needs of disabled
24 children and young people are met.

25 There is a description, my Lady, of some of the

1 steps that are being taken, and then, from paragraph 150
2 onwards, what is said is that, without detracting from
3 that acknowledgement, the Scottish Government would
4 nevertheless submit that the framework does not assume
5 that because someone is a particular age or they have
6 a particular condition, they therefore lack capacity or
7 are not capable of providing a competent view. The
8 government's submission is that the framework does
9 recognise the particular needs of disabled children and
10 young people, and there is a description, my Lady, of
11 a number of pieces of guidance that are intended to
12 support those who are implementing the GIRFEC framework
13 in relation to children and young people with
14 disabilities. Again, I don't intend to go through that
15 in detail.

16 The final main chapter is on the Independent Review
17 of Inspection, Scrutiny and Regulation. And your
18 Ladyship has had evidence about that previously, so
19 I won't speak to that in oral submissions.

20 My Lady, I would wish to make, subject to your
21 Ladyship having other questions for me, some final
22 remarks.

23 In her evidence on 27 May 2025, Janie McManus said:

24 'I want to reiterate my previous commitment to
25 listening. I will engage fully with the evidence

1 presented during these hearings and the questions raised
2 so that I can reflect carefully on any further
3 improvements needed to strengthen inspection practice.'

4 The Scottish Government adopts her words as
5 a statement of its wider intention to listen and to use
6 what it has heard from the Inquiry to inform further
7 improvements in the provision of services for children
8 and young people with long-term healthcare needs,
9 additional support needs and disabilities.

10 Thank you, my Lady.

11 LADY SMITH: Thank you very much. I have no other questions
12 or comments, Ms O'Neill.

13 It just remains for me to thank everybody who has
14 provided closing submissions today, and some of them
15 provided in such detail, and clearly a lot of work has
16 gone into advising me in relation to these submissions
17 of the approach by each of the organisations who had
18 leave to appear.

19 I'm very grateful for all the hard work that has
20 gone into it and for us being here until 4 o'clock on
21 a Friday; not easy when we have been working very hard
22 at this phase.

23 That now completes Phase 9. Phase 10 is due to
24 begin before the end of the year, but I can't give you
25 specific dates yet. You will need to watch the website

1 and keep in touch in relation to that.

2 Have a good weekend. I hope everybody in the room
3 at the moment is able to go away and relax.

4 Thank you.

5 (4.05 pm)

6 (The Inquiry adjourned to a date to be later confirmed)

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