Scottish Child Abuse Inquiry

Witness Statement of

Peter DORAN

Support person present: No

1. My name is Peter Joseph Doran. My date of birth is ______1954. My contact details are known to the Inquiry.

Qualifications and career

- I graduated with a BA (Hons) Economics from the City of Birmingham Polytechnic in 1975.
- 3. I had no idea what I wanted to do after finishing my degree. I got a job with a small, family printing company. I started off driving the van for them but then they realised I had a bit of a brain so I ended up as assistant to the managing director.
- 4. During this time, I did a lot of voluntary work with the Birmingham Volunteer Bureau. I got interested in public and social policy. Through that, I got employment as a trainee with West Midlands Probation Service. I was a trainee for two years and during that time, one of my work options was in a probation hostel for women and children. This began to develop what would later become my career in residential provision.
- I got sponsorship from the Home Office to do a Masters at Leicester University in Social Work Policy and Practice, which I finished in 1980. I also gained the social work professional qualification while I was there.

- 6. I went back to work for six months with the probation service in West Midlands and then returned to Ireland. I worked as a social worker with Southern Health and Social Services. During that time, I also did some sessional teaching at Queen's University. I also obtained an Advanced Certificate in Social Work (Management and Leadership in Personal Social Services) from Queen's University, Belfast in 1984. This is MBA level for senior managers. I was the lowest level manager in the cohort.
- 7. I moved to my first management post as a social worker from 1982 to 1985, as principal of Bocombra Children's Services in Portadown, which had a big residential element to it. There was a big mix of politics and religion in children's regulations. We had to, for example, make sure all children attended church on a Sunday, which is not an easy thing to do with teenagers in residential care. I was also teaching on the Masters level Child Protection course at Queens University.
- 8. The inquiry into Kincora Boys' Home in Belfast set the ball rolling on issues of abuse in residential childcare. There was a pattern of significant abuse with a lot of high level people involved, and a lot of politics between politicians and police. With this and the work that I was doing, I became very highly sensitised to the issues of abuse and the culture in residential child care.
- 9. By 1984, the situation in Northern Ireland was becoming intolerable and my wife and I had three children by this time. We moved to Edinburgh after I took a job as Principal Officer in Edinburgh and Lothians Social Work Assessment Centre and Secure Services. This was the old Howdenhall. The secure unit was small at that time.

Residential care in Scotland

10. I came to Howdenhall about a year after it had opened its doors. It had previously been a locked unit. The building was a disaster, and it was not a very good or well managed establishment with a lot of untrained and unqualified staff. There were a lot of exmilitary and ex-police who were very much used to a key culture.

- 11. Within a short period of time, in discussion with the directorate at Lothian Region, I came up with a plan to close it. There were two open units, each with twenty beds, as well as a five bed secure unit. I closed one of the larger open units. That allowed me, within the HR policies of Lothian, to move a lot of the staff who were not of the calibre that I would expect. They went on to do other jobs that were not in childcare.
- 12. We then opened two smaller community units at Comiston and Cruachan and recruited new staff, and began to change the culture.
- 13. We were left with one large twenty bedded unit at Howdenhall, which I reduced to ten or twelve beds, and the secure unit was the hub. I began the process of helping to design what was to become the new St Katherine's Secure Unit. That would in theory allow the complete closure of the old site.
- 14. In 1990, the director of social work in Lothian, John Chant, said that they were setting up a new inspection unit and that he wanted me to do it. Myself and one other person, Lawrie Davidson, became the first inspectors for children's services. There had never been internal or external inspections of childcare services before. During that time, I wrote the standards that became the basis for the Care Commission standards. I was heavily involved in the development for childcare services. I did this from 1990 to 1994.
- 15. In 1994, I became a single parent to my four children who were aged 5, 7, 9 and 11. I took a career break for two years to focus on them.
- 16. When I began to look for employment again in 1996, a team leader position at Harmeny came up. I had been aware of Harmeny from my previous role because children would often be sent to the assessment centre or sometimes the secure unit because Harmeny couldn't cope with them. I knew Harmeny had a history of possibly well-intentioned but not very high quality childcare and education. I was a team leader at Harmeny for about six months, before being appointed head of care from 1997 to 2005, and then CEO from 2005 to 2010.

- 17. I then did some work for Scottish Borders Council as an independent chair on fostering and adoption panels from 2010 to 2017. During that time, I was also the chair and author of the 'Doran Review,' which was officially titled A Strategic Review of Learning Provision for Children and Young People with Complex Additional Support Needs.
- 18. From 2012 to 2018, I worked as an independent consultant and trainer. Capability Scotland had two residential schools in Lanark and Renfrewshire, and they wanted to move and develop their resources. They asked me to come in and help them review what they had, and either restructure or make recommendations. For two and a half years. I worked with them to review their schools.
- 19. I completely retired in 2018 but continued on some trustee positions with voluntary organisations, as well as working on my own academic work relating to residential child care, having jointly with two academics published a book in 2013 called Residential Child Care in Practice.

Harmeny School, Balerno

- 20. Harmeny was a residential care and education facility for approximately 24 boys and girls of primary school age, mainly aged seven to ten. I recall some children being as young as six, and the upper age later increased to S1 and S2 age.
- 22. I went along to talk to them and I got the feeling that they were up for development and change.

23. I joined Harmeny School in 1996 or 1997 as the team leader of one of the four residential units. After six months, I became the head of care, which role I continued until 2005 when I became CEO, which I did until I retired in 2010.

My role and responsibilities

- 24. I lived on the grounds of Harmeny School, both as head of care and as CEO. I also had my own house in Edinburgh and a flat in Galashiels, so I would go away to my own home most weekends with my family. As head of care, I was on the management rota, so I would be on call every second or third weekend so I would stay at the house on Harmeny grounds on those weekends.
- 25. As head of care, I would be at the school at 7.30 am and I went home when the job was done. I had to do a lot of administrative work, including management work and setting up policies, so I was in the office a lot. I did also spend a lot of time around the school and was known to the kids on a first name basis. I would have meals with children and would join in play and kick a football around with them. My youngest son, who went to Balerno Primary School, and was ages with some of the kids, would be out running about with the children in the grounds as well sometimes.
- 26. As CEO, I had more managerial level responsibilities but I was still accessible. I would be seen around the school with the children and young people.
- 27. I was very much around the school whether I was working or not. That said, you have to be disciplined and create space for yourself and have your own life and family as well, which I did. As time went on and the more competent the management team got, the more I was able to have my own time. I did still believe in visibility, however. I had an in-built thermometer and would walk through the school and get a feel for how things were that day. It was a way of keeping my finger on the pulse. I didn't always intervene if something went wrong because by the end, I had very experienced and competent staff. If any issues arose, they would have been dealt with by the appropriate school managers. One of the reasons I retired was that I had a very competent management team and I felt I had made my contribution.

Layout

- 28. When I first arrived, the school was a row of wooden huts. There were four residential houses. Two of them were within the main building and two were in cottages in the grounds. The cottages in the grounds were Eason and Caroline, and in the main building were Owls and, Pandas.
- a new school around the main building. We closed the two units that were in the main building and built two new units in the grounds and refurbished the two old ones. So there were now four cottages in the grounds, each with six children in them. The houses were then named Eason, Caroline, Holly and Hawthorn.
- The new school was operational by about 1998.
- 31. Harmeny had huge grounds with a lot of area for outside play with rope swings. There was a river nearby.
- on the grounds as SNR and I lived in a house for head of care. When KYN I became CEO, I moved into the lodge and the head of care house was made into an extension of residential facilities because nobody was going to be living there. It wasn't a requirement for head of care to live on the grounds. The only other staff member that lived on the grounds when I was CEO was the estate manager who looked after the gardens.

Purpose of Harmeny

33. The profile of a child in Harmeny was that they came from previous multiple care and education placements. A very small number were with their birth family. Almost all of these children had difficulties with communication and behaviours. Some of these children had quite significant mental health problems that were likely to continue throughout their life.

- 34. Harmeny's role was to ideally reverse that. The goal eventually was to reintegrate children into mainstream schools and a stable family situation. How you measure success is different for every child. For some children, just surviving childhood was a success and we would care for and educate that child safely and securely in a relaxed environment. The capacity for development for some children was limited.
- 35. I did some research later on, when I set up an early intervention centre in conjunction with West Lothian. The research wasn't centred around Harmeny, but it did show that almost every single child who was in Harmeny while I was there, had been identified as having additional needs from as early as pre-school or by primary one at the very latest. After that came a succession of interventions. While they were well intentioned, they hadn't significantly altered the behaviours of the child or enhanced the capacity of the child in the ways that you would want. This meant that by the time the child came to Harmeny they were extremely troubled and needy.
- 36. Harmeny was a forty week school for children when I first started there. The majority of children went home or to foster placements every weekend and for the holidays. There would be some children who would go home one weekend and stay at Harmeny the following weekend.
- 37. The children would therefore have one system of care and education for five days, and then a completely different one at the weekend with their foster families or birth families. This would be for longer periods of times during the holidays. It was very difficult for some children to cope with going home.
- 38. Although it was more financially viable within the staffing structures when I joined to have the children go home at weekends and holidays, I persuaded the board to develop an option to keep the children at Harmeny where their home life was not suitable. I felt it was necessary to offer that, especially where the environment at home or in foster placements was not stable for them. We then moved to a 52 week provision. This happened about three years after I started at Harmeny.

- 39. There were six children in every cottage and two or three members of staff on duty at any one time so the ratio of staff to children was quite high.
- 40. There were also a few day pupils at Harmeny. They were treated just like the residential pupils in the sense that they had care plans that were developed and reviewed to meet their needs. There weren't many of them and their numbers varied, but there were about two per cottage. They were assigned a cottage and that would be the group they would be part of.
- 41. Some residential pupils could progress to being day pupils if they had a foster placement within travelling distance or if our work with families had stabilised the home situation. We would maintain that contact with them as a day pupil, until such time that they were able to go to a community school. It depended on each child's individual circumstances.

Management structure and staff

- 42. At the head of the organisational chart was the principal, who became CEO. Then there was a head of care, head of education and head of HR and finance. That was the senior management team.
- 43. When I started at Harmeny as a team leader, SNR was KYN. There was a head of care above me called Jan, who was a social worker. She was my manager. She left the job about six months after I started and I got the head of care post. Then I reported directly to KYN and the senior management team.

 SNR at that time was PNC.
- 44. On the care side, under the head of care, there were four residential unit managers who headed up each house. Each manager had a staff team below them. Each house also had a housekeeper. The housekeepers were pivotal figures in the house. They were like maternal, aunty figures and the kids had really good relationships with them. They were a real valued resource.

- 45. On the education side, there was the head of Education and a senior teacher. There were six classes and each one had a classroom teacher and a support member of staff.
- 46. I also recruited a school social worker called Pauline Gilruth, who was also the child protection officer. She became the first child protection officer. Later, with training, we expanded this so there were more people in-house who could do that role.
- 47. After we moved to the 52 week provision, we recruited a huge number of staff. There were then about ten residential care officers, not including night staff, plus a team leader, in each cottage. Then there were three or four residential managers above that with the care manager overseeing them all. There were over one hundred staff. These numbers helped develop a management structure whereby there were the unit managers, then a team of residential managers, who reported to the care manager.
- 48. PTY when I became CEO. He was a residential manager and applied for the job internally.
- 49. I recruited a magnificent SNR called from down south but she left after about eight months to a year because her partner got a job elsewhere. Then I recruited a woman called who came from a local authority. She was also excellent. Laterally became SNR.
- 50. By the time I left, there was a very highly qualified management team and the school was self-regulatory. The culture was so imbedded that it would have been almost impossible for anyone who was not genuinely committed, dismissive or had unhealthy attitudes, to go unnoticed.

Culture

51. Almost all of the children at Harmeny had, at some time, serious communication difficulties which often manifested as aggression or unruly behaviours. Some of them couldn't cope.

- 52. When I arrived at Harmeny, it was caring, nurturing and well-intentioned but the staff were largely untrained and unqualified. Their ability to manage stress and challenging behaviour at the level that was needed, was sometimes limited.
- 53. There is a simplistic way to look at the model of residential care for children of all needs. There is warehousing or horticultural. The warehousing model is about containment. This was what existed in Howdenhall. Although the staff may have been well intentioned, it was about keeping the child there until somebody else decided what was going to happen to them.
- 54. The horticultural model is about development, therapy and growth. As well as the predominant approach to make sure the child is physically safe, fed and given any medication they need, there also needs to be an emphasis on the child's potential and how the child can achieve more. It might seem simplistic but this strength based approach is really quite sophisticated and means everything is centred and re-framed around the child.
- As head of care, I did an awful lot of personal training linked to personal development and cultural change in Harmeny. I recognised that there needed to be a huge input into the professional development of the staff. Training and qualifications went along with that, but I was initially much more interested in establishing a positive caring culture amongst the staff, across the care and education divide.
- 56. There were teachers who hadn't been trained as special school teachers.
- A lot of practices developed over the years. I learned painfully that staff needed to have an incredibly high level of understanding of the nature of children's communication where the child has poor communication skills. This required reframing the staff's understanding of behaviour as a means of communication.

- 58. It may sound very simple but if you are a teacher or member of care staff who has been spat at or bitten by a child, it takes a serious support, training and development network to help them stand back and not react.
- 59. I had more of a development agenda when I arrived there. To underpin the developments we made in training, the biggest change was in reframing the culture to move to a strength based approach.
- 60. There was a lot of development of Harmeny from 1995 onwards, changing the focus of the school from a boarding school that sent children home at the weekends to new care arrangements for the children, recruitment of capable staff, training and development.
- was very able in a lot of areas. He acknowledged that the advancements in therapeutic care practice were my sphere of knowledge.
- 62. I had to find and source my own avenues for development. These included my own external contacts. I was doing some sessional teaching at Edinburgh and was heavily involved with the academic staff there. There were also a number of HET board members who were experts in different fields. I also helped to set up a number of professional practice sub-committees. I also had support and mentoring from The Scottish institute of Human Relations.

Recruitment

- 63. When I first arrived at Harmeny. There were some people there who I thought needed to think of going into another line of work. They were well intentioned but didn't have the skills or potential to undertake the training I thought was important for therapeutic work.
- 64. I started recruiting staff quite quickly after I joined Harmeny as team leader and continued to do so as head of care and CEO. I would recruit staff whenever vacancies arose. I was able to employ people who I had seen start their careers elsewhere,

including some from Howdenhall, Cruachan and Comiston. I was able to recruit key people into key positions who I knew to be of a high calibre.

- 65. There were huge levels of recruitment when we moved to a 52 week provision. This meant that we were able to bring in a significant number of very capable care staff. Their backgrounds could be anything from farmers, North Sea oil workers, students straight from university, Masters and PhD students. As head of care, I was more interested in their attitudes and values and if they were trainable. Part of assessing that was science and seeing how they responded to questions, and partly whether that person was able to engage well with the children.
- 66. There was the traditional face to face interview. Then we would put people in scenarios and assess how they would work under pressure. Anyone could give a model answer in interview but we had methods of drilling down to unpick how engrained the spoken attitudes and values were in their practice.
- 67. They would spend time around the school, and we would see how they reacted in situations with other staff and children. We would have them do at least one shift, supervised of course, and see how they interacted with the children. It would be a length of time that seemed meaningful. Sometimes, that was enough to put people off and they wouldn't want the job. We would also ask the children on their feedback on the applicant. We would evaluate their answers, for instance we would disregard if e.g. comment was made about an applicant because of the way they dressed. We were sophisticated enough to be able to evaluate the way children felt about the person.
- 68. We would give written scenarios that interviewees would have to respond to, especially for management posts.
- 69. Written references from two previous employers were obtained, as well as PVG checks carried out. All the basic requirements were met before anybody was even allowed through the door. Sometimes we would speak to previous employers to get more information on anything that was of interest.

- 70. We had a number of volunteers and the exact same process of vetting and references were obtained for them as would have been for any employee.
- 71. As head of care, I also did some sessional teaching on Solution Focussed Brief Therapy on the Masters course at Edinburgh University. I also supervised some of the students doing placements at Harmeny. Then, if they made a decision to come back and work there, it was an incredible endorsement.
- 72. When I became CEO, post was advertised. I recruited a guy called who looked like he was top notch with his CV, interview and references.
- 73. I realised within a month that he was less competent than people even two tiers below him at Harmeny. The staff he was managing were better trained and more therapeutically aware than he was. Luckily, he realised himself that he had bitten off more than he could chew and he moved on.

 PTY applied for and got the job, and he was excellent.
- 75. Recruitment of teachers was an issue because it was a struggle to get a volume of applicants who wanted to work in a setting as challenging as Harmeny. It was a struggle to find teachers When we employed a good teacher, we nurtured and held on to them.

- 76. Teachers were all qualified and had worked in mainstream schools. A very small number had special education experience. A couple had done placements in Harmeny and then came back at a later stage having made a positive decision to work there.
- 77. As CEO, I was involved with the recruitment of teachers, but I didn't sit in on every interview. That was the role of the head of education. I would meet prospective teachers and they would spend some time at the school. We were generally in agreement about who to employ.
- 78. We offered written references for our own employees when they moved on to other jobs. Latterly, on advice from external HR people, we moved to a position of just confirming the dates that someone had worked with us, instead of the traditional detailed reference.
- 79. If somebody did leave under difficult circumstances, if there had been an incident that was proven after an internal investigation, or any disciplinary action had taken place, then we would communicate that to future employers. If an incident had been investigated and was deemed to be unfounded and required no further action internally or externally, then we wouldn't necessarily include that in a reference, especially if it was years after the event.

Training and development

- 80. We had an induction training for every new member of staff, as well as ongoing training. Latterly, there was training going on every day of the week for different levels of staff.
- 81. I introduced Crisis Aggression Limitation Management (CALM) to the school. At that stage, it was the only recognised and approved method of physical intervention. We had our own internal instructors and evaluation. There was a requirement to stay compliant with CALM so training for that was regular. Staff needed to be reappraised and reassessed as to their competency, and that had to be externally communicated to CALM.

- 82. The school social worker and myself became really interested in finding a model that we could use to train and teach staff and really embed that into the culture of the school. We centred on Solution-Focused Brief Therapy (SFBT), which is fundamentally a strength based approach. It was developed by a couple of impressive people called Steve de Shazer and Insoo Kim Berg, who started the Brief Family Therapy Centre in Milwaukee in USA. The interest in the therapy spread throughout Europe.
- 83. After doing the initial training, I visited a school in Sweden and spent some time there looking at how they implemented SFBT. I then got a psychologist from Wales, who was a skilled practitioner, to come and do a whole school four day training event at Harmeny. This was around 1999 or 2000. This involved the teaching and care staff, as well as the cooks, cleaners and gardening staff. I felt the maintenance staff needed to know how and why we were changing our approach to children, even if they were never directly involved.
- 84. From there, we started to train up every new member of staff with two day training on SFBT. Initially I delivered all this training but then I trained up some of the middle managers to deliver it and then it cascaded down.
- 85. Generally speaking, the quality of teaching, training and assessment of SVQs was limited at some of the colleges, which I could see when people joined Harmeny. I took the decision to set up our own training school. We got approval from SQA and became capable of delivering our own SVQ and HNC in social care, in-house from our own school building. We effectively became a mini college for our own staff. This was in place by about 2002 or 2003.
- 86. This meant that we could hire unqualified staff and have them registered with SSSC whilst they undertook in-house training. I preferred this because it meant that I could concentrate on the applicant's attitudes and values, which I thought was more important because those things are harder to teach. Then, once we hired the right

people, we could train them up in house. SSSC had a three year period within which people needed to be registered.

- 87. We then recruited two training officers to supplement our management team. They were running training events for whatever the need was.
- 88. All of our managers were qualified so they already had their SVQ and HNCs or were social work qualified. We then got them through assessor awards so that the assessing could also be done in-house. It was very efficient and meant we also had control over the quality of assessment. We were still overseen by SQA so it was no different than doing it in a college. We were regularly evaluated to ensure that the level of training and assessment met the required standards.
- 89. A number of our care managers took on responsibility for particular areas of training.
- 90. All new members of staff who came in, including the teachers, did the same induction training, which included SFBT and CALM and child protection. The teachers also had their own professional standards and development laid down that they worked to.
- 91. I felt very proud of the staff who I saw come into Harmeny at the start of their career and develop as time went one.
 - Supervision / appraisal / evaluation
- 92. I more or less worked autonomously on my own development and training when I was head of care, but within the framework of reporting to the Board and the professional practice sub-committees.
- 93. I recognised that the key element for staff development was to have the right people in the right place supervising, supporting and monitoring, who were also prepared to challenge their colleagues. That was how the culture would change and did change.
- 94. There was supervision from the line managers, who would have regular meetings with the staff they managed. The expectation was that this would happen regularly. That

was for all staff and they would be recorded and have appraisals following that. This was something that I introduced, but it was an expectation and something I had seen happening where I had previously worked. We were supposed to be doing it so we did it. As CEO, I had weekly supervision with the head of care and education who I managed directly.

- 95. All staff meetings happened weekly and we had senior management team meetings weekly.
- 96. A culture of learning and development was created in Harmeny and this was overseen by competent managers.

Policy

- 97. There was a thin folder of policies when I started. The baseline was low for all residential services and special schools at that time. The external expectations in 1997 and before were not as stringent as they later became. There would have been papers on certain things but there weren't proper policies.
- 98. Lots of policies and procedures were written up from scratch to very high standards while I was there. We had a policy on everything that you would expect. Harmeny records would have to be checked to see what they all were, but there were policies for child protection and whistleblowing. I wrote many of them initially.
- 99. Nobody had child protection policies back then and neither did Harmeny when I started. We very quickly developed a child protection policy and the school's senior social worker was initially the designated child protection officer. She had done the post-qualifying child protection qualification.
- 100. As time went on and we had the right staff in place, the initial draft of a policy could be written by the residential managers' group and then passed to the senior management, where it would be worked on further and then maybe go to the policy practice subcommittee. It wasn't just one person sitting writing policies.

- 101. As reviews and inquiries of residential care came out, we would identify where we had our own policy gaps, like HR and staff related polices, and then develop those. Things like child protection and safe care, holding safely, were national initiatives so they would influence how we developed our policies. A lot of that information came from government documents.
- 102. I was very tuned in to what the national agendas were through my own professional associations, so I would know that these were areas we needed to think about. We worked on policies from a point of knowing what was expected externally but also from our own self-evaluation and knowing which areas we needed to work on.
- 103. Most importantly, the policies were implemented. Policies are useless unless they are embedded in practice. I could write policies all day long, but if the staff weren't implementing them then they were just pieces of paper. Therefore, there was a need for both policies and the right staff to implement them.
- 104. We developed a significant policy handbook in a binder that could be updated. New policies would have been introduced to the staff at meetings, but many of the staff members would already have been involved in the discussions about and drafting of the policy. New staff would see the policy handbook as part of their induction.
- 105. We were on a continuous journey of improvement, learning and responding to national guidance and advice, as well as our own internal learning. They were working policy documents, not just written and filed.

Child protection arrangements

- 106. Our child protection policy was very simple: Observe, Record, Report. If you saw something that was in any way concerning, you observed it, you recorded it and you reported it. This was the most simple policy in the world because it passed the responsibility onto the appropriately qualified member of staff.
- 107. If a child raised an issue with a member of staff, that would be recorded as an incident on our internal incident report form. An internal investigation would be carried out as

a matter of course. Some incidents could be minor and some could be serious but every incident was treated as an incident to be investigated. It would be overseen by a member of management. If it was a member of care staff it would be their line manager, then the residential manager, care manager and ultimately the CEO. They would also be seen by the child protection officer. All incident forms had to be signed off by a senior member of staff.

- 108. If an incident was investigated internally and the child said they were just angry at the time, then that would be the conclusion. It would still be written up. The more serious ones would require further investigation and communication with external agencies, such as social workers or an educational psychologist. We would present the information to them, possibly with an evaluation or opinion. It would then be for them to decide how to proceed if further action would be required.
- 109. If any of the national child protection guidance or legislative frameworks contained an official definition of abuse then it would have been incorporated into Harmeny's documentation.

External monitoring

- 110. Inspections by the Care Inspectorate were carried out regularly. They happened at least once a year on an announced basis. There were also unannounced visits which happened as and when, which we were never given any notice for.
- 111. Joint HM Inspectors of Education and Care Inspectorate inspections happened less frequently, maybe every couple of years. All inspection reports are on the Care Inspectorate website.
- 112. During the inspections, the inspectors would speak to the children outwith the presence of staff. The inspectors would go through their processes, and their detailed methodology is available in the inspection reports, which can be found online.

Record-keeping

- 113. Staff at Harmeny were required to keep daily logs, care plans, education plans, incident forms, minutes of reviews and meetings. The records kept were everything that was required by guidance, legislation and frameworks and they would have changed over time in line with those. The guidance which comes with legislation would be more relevant as it came with more detail.
- 114. At the end of every shift, staff would write up a daily log about who was on shift, what they did and how the day was. They would write about any difficulties or issues that arose. It provided a general overview for the next member of staff coming on shift and let them know what action, if any, needed to be taken. Most of it was mundane.
- 115. The key workers were required to write a report after every key time session, detailing what happened.
- 116. There was an incident report form that had to be completed by the staff involved for every incident that occurred. They all required investigation and the report would have to be signed off by every level of management. There would be a paper trail of the incident, how it was dealt with internally, how it was reported and how it was concluded upon. Those statistics were regularly reviewed. I would know how many reports there were, how many restraints there were, how many incidents there were, what the nature of the incident was. I would also have a record of which staff were involved.
- 117. In the earlier days it had to be done by hand on paper, and the paper trail for that would be available. Latterly, a database was developed that collates all that information so with almost a push of a button you could pull every incident by nature, type or involvement.
- 118. All of the records should still be held in Harmeny School.

Children at Harmeny

Placement

- 119. Children were placed in Harmeny from all over Scotland and usually because the placing authority couldn't cope with them, because they had either exhausted all options or they didn't have the facilities.
- Most children would have had educational psychologist assessments. These would generally be required before they could be placed. Some children may have had mental health involvement from Child and Adolescent Mental Health Service (CAMHS). A small number would have psychiatric and psychological input. All of this information would be passed on to us before any placement.
- 121. I wouldn't accept an admission unless it felt like we could make a difference for the child. We placed high demands on the placing authority to work in an integrated way with the child's family or fostering services. We expected a whole package around the child that had clear objectives about what the placement was about, how it was going to be monitored and how the child was going to maintain and develop links with their home area, birth family or foster parents.
- 122. Harmeny took in children of primary school age. They were majority boys but there were a significant number of girls. The youngest in my time was about six years old, and by the time I left Harmeny, we had children up to S1 and S2 age. This was because they hadn't reached the capacity to be in a new family or access provisions in mainstream schools or other independent schools that would offer an environment continuous to what the children had experienced in Harmeny.
- 123. The cottages weren't divided up by age or gender. There would be some consideration about what would be a better fit for a child when they came in. We would consider, for instance, if a new girl coming in would be better being placed in a cottage where there was another girl. Ultimately, the pressure on admissions meant that they would go wherever there was a space available. Very rarely, we would move a child if they

weren't settling in a cottage because of friendships or whatever, but that didn't happen often. We were trying to create the feeling of a mini community within each cottage so there wasn't willy nilly change, but there was as much scope as possible to find the best fit for each child.

Daily routine

- 124. Children woke in the morning, got showered, dressed and had breakfast. They would have some quiet time in the cottage before walking over to school, supervised by the care staff.
- 125. They would have school in the morning and stop for break time. They could choose an activity for break time, like gym or art work, and go to that, again supervised by care staff. Then they would go back to class and stop for lunch. Care staff would bring them back to their own cottages for lunch. Day pupils would go to their assigned cottage for lunch. After eating their lunch, they would have some more time to either have quiet time, read, play electronic games such as PlayStation or play outside. Harmeny was a child's paradise for outside play with extensive grounds, rope swings and a river.
- 126. They would get walked back to class for the afternoon. During this time, the early shift care staff would do a handover to the back shift who were coming on and tell them anything they needed to know. This would be anything about their behaviours or family issues.
- 127. After school, the back shift staff would go and collect the residential children and bring them back to the cottages. Then it would be tea time and after that it would be evening activities, which could be anything like reading, TV or play station in the house, outdoor activities, or organised trips. Then it would be bedtime.

Mealtimes / Food

128. The children had all their meals in their own cottages. The day pupils would have their

meals there too.

129. The food was prepared in a central kitchen in the main building and then brought to

each house by the housekeeper. It would then be served individually to the dining

table. At various stages I looked at the possibility of having cooks in each house but

we never got to do that. I don't know if that was developed after I left. At the time, it

was as normal as we could make it.

130. There was more than one option provided so kids would choose what their preference

was from the options. I think there would be a meat option and vegetarian option as a

minimum. The staff sat down with the children and ate the same meals.

131. There was no requirement for children to finish what was on their plate, but they would

be encouraged to eat what they could. Healthy diet and healthy living was a feature of

every care plan so we wanted to encourage the children to eat well. Some staff were

more zealous about healthy eating than others. The culture was of encouragement to

eat and make healthy choices but there was no punitive action if they didn't.

132. The children had access to the kitchens in their cottages to make sandwiches or have

snacks, like biscuits and crisps, like there would be in any home. This was monitored

so that they weren't eating a whole packet of biscuits before dinner.

Sleeping Arrangements

133. Children all had their own bedrooms.

Washing and Bathing

134. There was a private bathroom in every cottage with a lock on the door, just like in a

family home.

Trips / Holidays

- 135. There would be weekend trips to, for example, the climbing centre at Ratho or swimming pools, country parks or beaches.
- 136. Some trips to Alton Towers or outdoor activity centres with overnight stays were organised. These would be during the holiday periods.
- 137. The outdoor education staff organised trips for children to go off into the mountains or camping, which could be two or three nights.
- 138. There would usually be two or three children, with a maximum of six, who went on any overnight trips. They would be talked about, sanctioned and approved. There would be a high ratio of staff to children.
- 139. There were protocols for taking children out and they were laid out. The trips were all meticulously planned for every eventuality. Safety was a priority and there were protocols for staying in contact.
- 140. There were no informal trips. There was an understanding that staff would not take the children on any trips that were not formally approved.
- 141. I don't think any staff would have taken a child to their own home. They would have no reason to. There was no rule to say they couldn't, but it was more an understanding that any trip or outing had to have a reason and purpose, and that it had to be sanctioned and approved.

Healthcare

142. The children were all registered with the local GP and dentist. The dentist would often come to the school and give health chats. Children would generally make an appointment and be taken to the dentist or GP in the same way my own children would have.

- 143. There was no medical officer at Harmeny. That was a historical thing. It wasn't in-line with what we wanted to do with creating a normal living environment. We did have good links with Lothian Region health boards paediatric services and staff.
- 144. All staff covered some health and safety, and basic first aid in their induction. They knew minimally what to do and who to call in an emergency. There were some designated first aid staff who had done the proper training.
- 145. Some children had medication, which had been prescribed by their own health authority from before they were placed with us. We had nothing to do with that decision, although it was our care staff who administered the medication within Harmeny. At one stage Ritalin was prescribed a lot. I don't know what it cost the NHS doctors to throw Ritalin at a child, rather than deal with the underlying issues.
- 146. All medication was centrally stored and locked, administered and recorded by two members of care staff. Meticulous records were kept and that was doubly checked.
- 147. I would never want a school like Harmeny to be involved in prescribing any medication to a child. More often than not, we were trying to get them off the medication. We had an input at reviews as to whether or not we thought there was any value in the child continuing to take the medication. This was usually in relation to ADHD or autism related medication. There would then be a medical review and it was a decision for the medical practitioners to make.

Schooling

148. The residential children and day pupils attended the school at Harmeny. When I arrived at Harmeny, most of the teachers didn't have the training to work with children with additional support needs. Recruitment was an issue because we didn't get huge numbers applying because many didn't want to work in such a challenging environment, and the ones who did apply were not special education trained to work in such an environment.

- 149. Traditional teachers couldn't cope with the children we had at Harmeny. That was why the children had ended up with us. Therefore the traditional teaching method of having children sitting quietly with a pencil, ready to learn, wouldn't work at Harmeny. We needed teachers with the right mindset, who wanted to work with children with special needs, and were prepared to go home with bites and kicks and spit on them. It was incredibly challenging work. When we did recruit the right teachers, we invested in them and nurtured them.
- 150. The teachers at Harmeny worked to the same national standards but were much more imaginative on how it was delivered. Curriculum for Excellence gave teachers a bit more leeway. The boundaries were not as rigid as it might seem from an organisational chart. The care workers would also work in the classrooms when required.
- 151. I didn't have much input into how the curriculum was delivered. That was the professional area of the head of education and teachers. I insisted on the implementation of the common Harmeny attitudes and values in our approach to children, and training that underpinned therapeutic practice.
- 152. We started an outdoor education centre with outdoor education staff. That opened up huge possibilities for all of the curriculum being delivered in a way children enjoyed and engaged with. As an example, if a new path was being developed outside then maths could be taught outside by measuring the path and working out how much volume of chip would be needed.
- 153. The goal was to reintegrate children into mainstream schools and we had really good relationships with Balerno Primary School and Balerno High School. Wherever possible, children would have a shared placement with care in Harmeny and some, if not all of their education in a mainstream school.

Chores

154. Children tidied their own room but that was about the most they did. Housekeepers and cleaners dealt with everything else to do with cleaning and tidying.

Visitors

- 155. There were areas of the school where visitors, like social workers, could talk to the children privately, or they could come to the cottage by arrangement. It was all arranged with the agreement of the social worker.
- 156. There was no particular vetting process of visitors because the main visitors were foster parents, who would already have been vetted before becoming foster parents. Any other family members who visited, would be coming by prior arrangement with the social worker. If there were prior issues with a family member then we would consider if the visit needed to be supervised.
- 157. Visitors could take a child out of the grounds if it had been pre-agreed.
- 158. Anybody we didn't know just turning up would be unlikely to have access to a child. Visits would be formally agreed beforehand. That said, if a child was going to the local school and their friends dropped by, that would be different and the child could see their pals.

Review of Care/placement

159. Any assessments that were carried out before the placement with us, like the educational psychologist assessment or mental health assessment, would be incorporated into their individual care plans when they came to us. We would reassess the child when they came to us in an on-going way and develop and amend as needed.

- 160. Children's care plans would also be reviewed by the external agencies who placed them. Some children would also appear at children's panels so we would provide reports for that and they would have their input as well.
- 161. Inspections also looked at the quality of care planning and review. They would look at the key worker notes to see that the goals of the child were being worked towards. That was another layer of reviewing the care.

Discipline and Punishment

- 162. There were clear expectations of behaviours that we wanted to see and wanted to see more of.
- 163. Any discipline was in the context of care planning. The general approach was not to think about disciplining, but to think about strength based approaches. There was encouragement of what we wanted the children to do, rather than what we didn't want them to do. That is a general way of putting it but it underpinned our approach.
- 164. We didn't have punishments. We would sometimes separate the child from the group or the group from the child if that was what was needed. I don't mean isolation, but just until the child calmed down. If this happened, it would be recorded in the daily log book, and also an incident form would be filled out.
- 165. I think withholding of pocket money may have been something that was used in some cottages, but it would be for a short period of time and not denied completely. That was probably the height of anything that was used. If a child was not allowed on a trip, that would be for safety reasons and not used as a punishment for being naughty, and it would be explained to them that they had had a difficult day and maybe it was best if they didn't leave the grounds that day. The decision to not go on a trip would be made by the residential staff and managers. It would be decided on an individual basis, and not a reaction to a rule being broken. We didn't operate like that. It wasn't a punitive system.

- 166. It is simplistic to have an offence and a punishment. That was irrelevant to these children. They'd probably have had every punishment under the sun before they came to Harmeny and they hadn't connected to that approach. We wanted to reframe their engagement with an understanding of what had happened, why they reacted the way they did and how we could do it differently next time. That type of conversational approach was used rather than taking something away or forbidding them from something. That approach was not helpful.
- 167. The teacher in a classroom might have a different approach and may have given old fashioned lines, but I don't know. If a child reacted in a classroom, then the rest of the class was as likely to be removed from the class for safety reasons, and then it was a case of containing the child in the class room until the situation could be defused. This was often better than removing the child out of the room because otherwise it would become a case of restraining rather than containing.
- 168. There was absolutely no corporal punishment ever, in any circumstances. That was generally understood by staff but it would also have been written in a policy and communicated to staff.
- 169. When the new school building was built, a separate building was built right next to the main building, where the gym hall was. It had two parts to it with two entrances. It had therapeutic potential with soft music and soft furnishings. I think it was called 'the support room.' It was an area that was sometimes used to take a child if they were displaying extreme violence that needed a high level of physical involvement. It was a space where the child could be restrained and taken to. That was only used for extreme behaviour management and if there was a high level of danger. It was not used for isolation and staff would be with the child the whole time. It was CCTV monitored and detailed logs were taken if it was used. There was no guidance on the length of time a child could be held because it would just depend on the situation, but there was very clear guidance on recording when it was used and how it was used.

170. Sometimes it was also used as a quiet space to go to. That space stopped being used towards the end of my time there because it was used so infrequently. It seemed to be needed less and less but I can't recall why.

Restraint

- 171. When I arrived at Harmeny, there was no system for managing restraint and no common approach. Staff were left to their individual responses. I found that unhelpful and unsafe for children and staff. There was no way of monitoring, or even holding to account, how somebody dealt with a situation because there was no common system. I did see some instances of inappropriate responses by staff in my early days there, which resulted in a number of disciplinary actions.
- 172. As an example, I recall seeing a child kick a member of staff and the member of staff instantly reacted and kicked the child back. It was a reaction and to contextualise it, he didn't have the training, support or framework to act in a different way. It was indicative where things weren't safe. I think I must have observed it because I remember it, and I took disciplinary action against him, as head of care.
- 173. The member of staff in question was called KLN and he was generally a good worker, but we had to lay down markers so he was disciplined and it was made clear to him that this was a high level of inappropriate response. I thought he had resigned but I have been reminded that we actually sacked him. This was around 1997 or 1998. His wife also worked at Harmeny and continued to work there. I can't provide more detail because my memory is hazy but this should all be held in Harmeny records.
- 174. I then introduced CALM in around 1998 or 1999. People have their views about CALM and restraint generally, but the children in Harmeny sometimes needed protection from themselves and from other children. This was a system of 'holding safely' rather than restraint. It also has a theoretical base to it, which was as important as the physical side of holding. All of the holds used had been bio-mechanically approved by at least academics or medical staff. It was the only thing like it that was available at the time

and that became our modus for any time a child had to be controlled to the point of physical hands on.

- 175. We introduced a whole-school training. We trained up key members of staff to be trainers and assessors so they could train other staff and re-assess them, yearly I think. This applied to everybody.
- 176. New staff would be trained on CALM before they even hit the floor. I was CALM trained and a CALM instructor, as head of care. I did have to use restraint from time to time.
- 177. As CEO, I ceased to have any involvement with using restraint. I did this because there was nobody above me to line manage me so if I had used any restraint, there was nobody above me to de-brief or carry out any management checks. There is no requirement from CALM that you shouldn't be implementing it if you have no chain of accountability. It was something I self-imposed and was my own decision. I would, however, still be asked to intervene by other members of staff because I was quite competent at dealing with aggression using a solution focused approach, instead of restraint.

Reporting concerns

- 178. I introduced a worry box, which was a box in every house and every classroom. Because the children had different levels of ability to communicate in writing, they were all given cards with their name on it. If they had a concern about anything, all they had to do was pop their card in whichever box.
- 179. The member of staff who opened the box and saw the card with the name would then go and speak to the child and ask who they would like to talk to about their issue. The process was very important because the child wasn't required to speak to the member of staff who first spoke to them and were given the option to speak to someone else, either in the school or externally. It was then the job of the staff member with the card to facilitate that.

- 180. It was a very simple method for children to raise any concerns within their limited means of communication. It wasn't massively used and the boxes weren't full.
- 181. If a family member of the child wanted to make a complaint about something at Harmeny, they could relay it to any member of staff. It didn't really matter who, because it would then be the responsibility of the member of staff to make sure it was passed on to the appropriate manager. Family members could also speak to the child's social worker.

Trusted adult/confidante

- 182. Each child had a key worker who they had 'key time' with. This was a one to one individual session linked to their care plan. This could be done as an informal sit down or as a walk in the park. It was about having a chat but also evidence that the key worker was working in a planned way towards achieving some of the targets that were set in the care plan or the education plan for the child.
- 183. The kids knew about the existence of the child protection officers and they knew the senior management system. They knew everyone by name and would say if they wanted to speak to a member of staff and it would be arranged, or they could just approach whoever they wanted to talk to.
- 184. Children also had contact with their social workers. Some were more active at seeing the children than others.
- 185. Children had the telephone numbers for their social workers, relevant family members and they had access to telephones. There was a phone in every house. Mobile phones were not that common then, especially for children.
- 186. We introduced another level of independent support and advocacy, and scrutiny. We contacted Who Cares, the organisation who represented children, to come into Harmeny as independent visitors. They became independent access points for the children. They would come in and attend meetings with children and make it clear to

them that they could be contacted and spoken to at any time. The children all had their contact details and phone numbers. It was another layer outwith the management structure. Who Cares had free rein to be supporting advocates for the children.

Discharge of child

- 187. Children would be discharged after a review decided it was time for the child to move on. The review would include the educational psychologist for the authority, social worker, senior social worker, Harmeny care staff, as well as the child psychotherapist at Harmeny. They were the main players but there could be input from any other external agency that was involved with the child.
- 188. There would be a corporate decision made in relation to the child because it was a commitment of resources from the local authority in relation to the child, to keep them there. They wanted to know that we weren't hanging on to children for the sake of it.
- 189. The review would agree the process of how the move would happen and the timescales for it, and what resources in the community were needed. The child would either be in attendance at the review or would be told of the decision straight away. The child would know what was happening as it was happening. Often the review was just formalising the decision that had already been discussed with the child. They would also be prepared by the care staff for what was going to happen next.
- 190. Harmeny would have records of the average length of stay of children. It was all statistically recorded.

Harmeny Educational Trust organisational structure

191. There was a HET Board that Harmeny School was answerable to. They had overview of care and education practice at Harmeny. The Board had a number of people with professional backgrounds, including lawyers and finance people amongst them. They met every two or three months and they took their role seriously. I would do Board

reports for them and they would ask for more information when they wanted it. They were active members who knew the staff, attended events and were known around the school.

- 192. The finance director, who was on the board, would be around at the school a lot. He would therefore know if anything was concerning in terms of finances to the board. It was all very transparent.
- 193. I did reports for the Board and attended Board meetings but I was not a Board member.
- 194. I set up professional practice sub-committees during my time as head of care, which were properly functioning by the time I was CEO. The need for these sub-committees was for the school to have an overview from external professionals, over and above just our own internal sense that we were doing ok. I thought this was necessary for an extra level of transparency, especially since we were an independent school and didn't have an authority above us, other than the Board. The sub-committees were intended to embed another layer of professional oversight of the care and education.
- 195. There were several sub-committees. There was a finance one that ran all the time, but the main one was the policy and practice sub-committee, which crossed over with educational, social care and psychotherapy expertise that straddled the care and education function of the school. The sub-committees met more frequently than the Board but I can't recall how often.
- 196. Some members of the sub-committees were HET Board members, like Margery Browning and Francesca Calvoresci, a child psychotherapist from the Scottish Institute of Human Relations, who I invited. Therefore the Board knew we were setting up these sub-committees and I suggested who else I thought should be on them and explained why. These meetings would also be attended by myself and the care and education managers.

- 197. The sub-committees would be minuted and they would be updated on topics of interest within the school like restraint and data protection. We had a reporting structure that could cover everything.
- 198. In the unlikely event that there was any conflict, then there were members within the sub-committees who also sat on the board, so the issue could, in theory, be taken to the board. That didn't happen, however, because if the sub-committee recognised that something needed to be done or changed within the school, we would just do it. Whether or not the sub-committees had power to make Harmeny School do something or not is a moot point because that issue never occurred. The general intention was for supporting and promoting development in Harmeny, and it was collaborative. It was very healthy.
- 199. It was hard and challenging work but the overall climate within the care and education teams, and board and sub-committees was incredibly positive and harmonious.
- 200. The sub-committees were an extra level below the Board level, but we would ultimately report to the chair of the Board. It was a big organisation because we had over one hundred staff and a big budget. We had not just the complex needs of the children to consider, but also the complex needs of the organisation. All the different levels of scrutiny needed to be quite tight.
- 201. Harmeny was a Grant Aided Special School (GASS) so it also had oversight from Scottish Government. I would report to SG and had regular contact with them and they would come to the school. I would provide them with information, as well as the Board. They were effectively our external managers.

Definition of Abuse at Harmeny

202. I don't recall that we had any formal definition of what constituted abuse. If there was a definition in any national child protection guidance then that would have been adopted into Harmeny's own documentation. Whatever would have been contained in national guidance would have been the parameters of what we considered to be abuse.

- 203. The common understanding is physical or sexual abuse, or inappropriate interference of any kind, but there are many more. My personal view is that anything that was not helpful to a child was potentially abusive. Containment, control, verbal abuse and being disrespectful are abusive. It could be passive abuse by not doing enough. A child being denied access to achieve their highest academic ability, in my mind, could be abuse.
- 204. With the strength based approach, we were focusing on what the child could do, and be helped, to do. We were focusing on development and care, rather than what constituted abuse, as that list could be enormous. This culture of development and care was the antithesis of containment, control and an abusive mentality.

Reports of abuse at Harmeny

- 205. I cannot recall anything with the heading of 'abuse' that happened at Harmeny. It really depends on the definition of abuse. In terms of sexual abuse, there were never any reports of this kind of abuse made.
- 206. In terms of physical abuse, I only recall that happening in the context of a child complaining about an injury following a restraint. This did happen from time to time. Anything of this sort would have been recorded in the incident reporting forms. They will all be in the records at Harmeny. I don't recall any incidents that occurred outwith what was recorded on incident forms.
- 207. I was subject to one investigation in relation to accuments for which have been shared with me by the Inquiry and is discussed further, below. I am not aware of any other investigation that I was subjected to.

- 208. I don't recall any police complaint or criminal proceedings being taken against me or any member of staff at Harmeny while I was there or since. I don't recall any civil proceeding being taken against me or any member of staff at Harmeny while I was there or since.
- 209. Nobody can ever be confident that all abuse would be detected and come to light. I have been involved in residential child care from 1982. I have had responsibility for hundreds of children and staff members. I have detailed the various stages of development within the organisations that I have worked for. I think anybody with my length of career would not be surprised that something could pop up from history.
- 210. Consciously, under my watch, am I as confident as I can be that nothing systemically abusive happened? I think I am because of the cultures that I helped to establish.
- 211. I wasn't a soft touch as a manager. I wasn't dictatorial and was inclusive, but nobody was in any doubt about the standards that I thought were appropriate and expected. Not just me, these were standards that the world of social work, social residential care and education clearly set out in guidance. I also looked at and studied the outcomes of other child abuse inquiries, for instance in Ireland and the UK. Not to be arrogant, but as far as one humanly could develop a culture and systems that were as safe as could be, while also promoting healthy development, I am pretty confident that I personally contributed to creating that. However, nobody could be arrogant enough to say that nothing could have happened under their watch. It could have but the whole approach was to create an environment where it was highly unlikely, and if anyone stood outside the culture, it would be noticed.

Other staff working at Harmeny School



212. This is the member of care staff who was kicked by a child, who he then kicked back. I saw it happen. He was disciplined for this at the time. I thought he had then resigned but I have been reminded that he was dismissed. I can't remember any more details but they would be in Harmeny files.

KLL

- 213. KLL was a guy who lived on the working at Harmeny. He was a care officer. I think he was only there for six months to a year after I started and then he moved on.
- 214. I never saw or heard of him doing anything abusive.

PMX

- 215. PMX was a housekeeper in Holly House. She was a local Balerno woman who I think had worked at Harmeny since she was a teenager.
- 216. I never had any concerns about her involvement with children.

KYN

- 217. KYN was SNR and then SNR who who have the was a big man with a big personality. He was absolutely committed to the development of the school. He was single handedly the impetus for the huge investment in the school and the new school building.
- 218. He was a teacher and not a therapist. He recognised this and allowed me to develop the care and therapy function of the school.

219. He played guitar with the kids and would have them singing. He had very little involvement in the physical care of the children. I never saw him discipline the children. I didn't see or hear of him doing anything that would have given me cause for concern, then or in hindsight.



- 220. PNC was SNR while I was head of care. He left around the time that I became CEO, which was in 2005, or just before then.
- 221. I do not recall that I saw or heard of him doing anything physical or using excessive force in a physical restraint. I wasn't concerned that he was a danger to children. He was more likely to give a loud telling off to a child.



- 222. PRD was a teacher. She used to sometimes cycle from Penicuik, along the Pentlands, to work, in all weathers.
- 223. She was a good teacher and had a good rapport with children. She had a good attitude and good values.
- 224. Nothing about her gave me any cause for concern.
- 225. I think she left before I left.



was the manager for Eason. He was there when I started working at Harmeny as team leader and had been employed for a while before I was there.

227. I never had any concerns about him with the children. I didn't see or hear of him doing anything abusive. I never had any concerns about his interaction or physical interventions with children. If I had, it would have been dealt with.



- 228. PPB was a care worker in Easson. I had no concerns about him or his practise.
- 229. I don't know if he was there when we moved to the 52 week working scenario. I say that because I don't recall him being around during the 52 week care scenario, but he might have been. He certainly left Harmeny while I was still there.



was a care worker in Caroline House. I can't remember the time period he was there but I don't remember him working there for years, maybe months.



- 231. RNZ was a care worker at Caroline House. She was there when I arrived. I can't remember if she moved into the 52 week care scenario but she probably did.
- 232. I had absolutely no concerns about her at all.



- 233. POJ was a young, female member of care staff. I think she joined during my latter period as CEO.
- 234. There was a whole raft of young blood that came in during that time. I didn't have that much involvement with them because, by that time, the care management were highly competent. They dealt with the recruitment and management and I had very little reason to get involved.



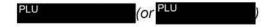
- 235. PMO was the gardener. He was a local man who had been there from day dot and was still there when I left. The estate manager, Andy, was his line manager.
- 236. I had no concerns whatsoever about his involvement with children.



- 237. PNB was a care worker in Hawthorne House. He was a main player in that team.
- 238. He was there during the 52 week period and may have still been there when I left. I can't really recall for sure.
- 239. I never witnessed anything other than him being a very competent and able member of staff. I had no concerns about PNB at all.



- 240. RCA was a care worker who was known as RCA. He worked in Holly or Hawthorn House. I can't remember when he worked there but I don't think he was there a long time.
- 241. I had no concerns about him.



242. I don't recall anybody of this name.



- 243. PNR was a care worker and was there when we went into 52 week care. I think he might have been in Easson but I'm not sure. In my view, he was a very competent and able guy. I had no concerns about him.
- 244. I can't remember when he left or what he went on to do.



245. I don't know a RCC



- 246. RCB was a group leader in Caroline Cottage when I arrived at Harmeny as group leader. He had been there for years before I started.
- 247. RCB was competent. I had no concerns about his practise. I think he benefited from all the training and development and embraced it. He developed his capacities as a care worker during my time there.
- 248. I can't remember when he left.



249. I know the name but I can't remember much else, so she didn't make that much of an impact on me, one way or another.



250. PTY was a residential care manager and then was made SNR when I was CEO.

251. I had no concerns at all about PTY. He was incredibly competent at all levels. He was great with children, management, the board, policy and Scottish Government.



252. I know the name but can't recall her.



- 253. PNL was a care worker. I have no idea when she worked there.
- 254. She was popular with the kids. I had no concerns about her.



255. I know the name but can't recall any specific details. She must have been a care worker and I think she was competent. I didn't have any concerns about her.



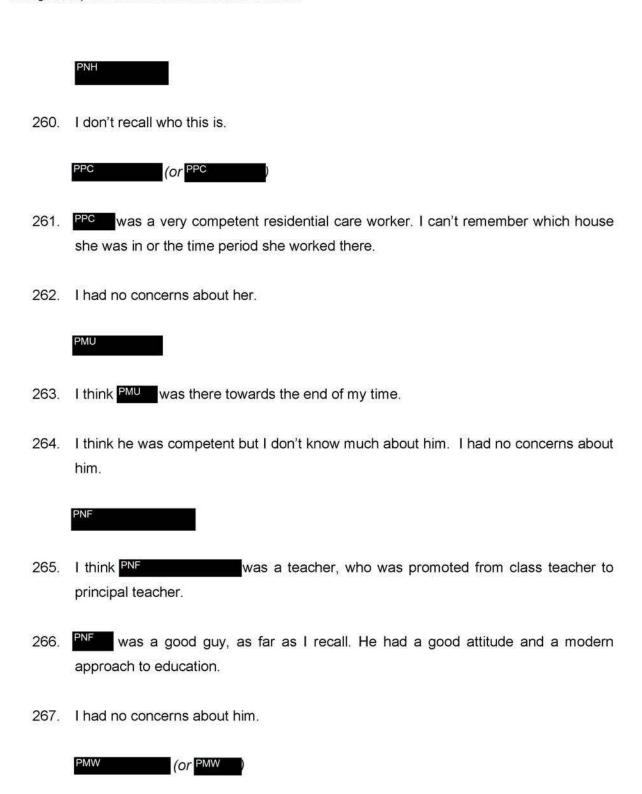
- 256. PKZ was one of the residential managers and oversaw several of the houses.
- 257. She was a first class worker, totally competent and had excellent values. I had no concerns about her.



- was a residential care worker in Easson Cottage, where he worked for at least a couple of years.
- 259. He was a very sound and super guy. He was popular with staff and kids. I had no concerns about him at all.

268.

was there.



was one of the new cohort that came in during the last couple of years that I

269. He was competent, well liked and popular with the kids. I had no concerns about him.

PMR

- 270. PMR was a residential care worker who worked in Hawthorne Cottage. He was there for quite a while and was there for the 52 week care scenario.
- 271. He was popular and a good guy. I had no concerns about him.

Documents shared with me

272. I have been provided with several documents by the Inquiry.

Extract HET-000000085 (Row 75)

- 273. I have been shown a document regarding an allegation by a child at Harmeny against a staff member, PNC about a physical incident that took place during a restraint on 2nd September 1997. It states that an investigation was carried out by me as head of care and that one staff witness was also interviewed.
- 274. I would have been head of care in 1997 but I don't recall the child or the incident that this is referring to.
- 275. The document states:
 - 'Investigation by Peter Doran, Head of Care. 1 staff witness also interviewed. Allegation appeared to be unfounded. SW informed... Not upheld No further action 10/09/2007'
- 276. If it was me that said that the allegation appeared to be unfounded, then I would want to see the investigation report and see what my rationale was for arriving at that conclusion. Once social work were informed, it became an external matter and then

the decision for no further action would not be made by Harmeny. They would have carried out their own investigation and let us know if no further action was required.

- 277. I do not recognise this document or the format of it. This is not a form that existed in Harmeny School while I was there. The document is referred to as an 'extract.' I understand that this is a document that HET have pulled together from their records as a response to the Inquiry. In that case, the wording is very important. If somebody has looked at the records and extracted information and summarised it, then that is a completely different document with different wording from the actual records. I would like to see the original documents, which HET should still have, before I could responsibly comment on it.
- 278. The incident reports were all put onto a database at some point but that might not go as far back as 1997, when this incident occurred, but there should be a paper record. Whichever authority that the child belonged to, should also have a record of the investigation that I allegedly undertook and what the conclusion was.
- 279. The extract goes on to say that I provided a personal reference letter to future employer at Starley Hall. I know that PNC was still working at Harmeny after 1997. He left around the time that I became CEO, which was in 2005, or just before then.
- I never saw him being abusive to a child.
- 281. I think that if I ever wrote a personal reference for somebody, I would not dodge issues if there were issues. I certainly had no issues about him being an abusive member of staff.
- 282. I think I did provide him with a reference I would have to see the reference that I wrote for him, which should be in Harmeny records, to comment fully . I emphasise that I would need to see the reference to be sure of the context of his relationship with me at the time he left.

283. If an allegation of abuse is investigated and appropriately dealt with, it wouldn't always be necessary to mention it in a written a reference. If an incident was proven or if there had been any disciplinary action then it absolutely would be disclosed to future employers. Incident investigations into children alleging that a member of staff had said or done something were not taken lightly, but if it was found to have no substance or need any other external input from police, social work or education, then it wouldn't necessarily be included in a written reference years after the event.

HET-000000031

- 284. This document is Minutes of a meeting of the Professional Practice Sub-Committee held at Harmeny School on Thursday 20 May 1999.
- 285. Under point 3 of the document, it reads:
 - informed the meeting about a member of staff who may not have been completely honest when completing his application form. This particular incident brought to light the need to update the application form and also to find ways to enable us to be more rigorous in checking applicant's backgrounds and references.'
- 286. I can't remember what this was in relation to. It is likely that somebody had inflated something on their application form. It may have been in relation to a teacher, and as head of care, I wouldn't have been involved in that. There may have been a disciplinary arising from that but I don't know. You would have to check the Harmeny records as they should have that information.
- 287. I think we would have re-looked at the application form and made sure there weren't any questions that should be asked that weren't asked and updated it. If we said the process should be more rigorous then I am confident we would have made it more rigorous, but I can't remember any detail.
- 288. Point four of the document goes on to say:

evaluated notes on the Behavioural Management Handbook indicating the awareness of the handbook by HET and HMI and their support of this. PNC detailed positive initiatives and concerns resulting from the preparation of the handbook.'

289. PNC is referring to PNC I don't remember the handbook I'm afraid. This was from when KYN was SNR and from before we had really turned the corner with solution focused, strength based approach. If PNC I led it, I imagine it probably originated from some Education Scotland guidance or document and maybe focused on the school within Harmeny. I don't know.

290. It goes on to state that:

'PD indicated that we have only recently changed the format of the Incident Report Form and this now enables us to get more detailed breakdown of incidents. PD agreed to draw up a table detailing incidents and action taken. Interest was also shown as to whether children actually see the Incident Report Form and whether they also have an opportunity to give their views. This was at present under review and the plan was that this would be discussed at a Middle Management meeting with the intention being that the children would be more involved in the preparation of the incident report form.'

291. This did happen. The children would see the forms and there was a section for their comments. This was the beginnings of the data collection system that I had wanted, whereby we would record all the incidents and have an overview. It was done by hand at this stage and was later superseded by a database.

Extract HET-000000085 (Row 66)

292. This extract document details a physical injury caused by me during a restraint on a boy called on 3rd March 2000.

293. It states:

'Internal investigation carried out by Pauline Gilruth, School SWr and KYN

SNR

Copy of investigation report sent to Wishaw SWD.'

- 294. The next section reads:
 - 'Internal investigation recommended "no additional action required". Covering letter to Wishaw SWD asks if further action or external review is deemed necessary but no response on'
- 295. Again, this document is in a format that I don't recognise as being a Harmeny document. It is also referred to as an "extract" and I believe it has been created by HET as a response to the Inquiry and summarises the event. It is not likely to be the wording that would have been used in the original documents.
- 296. Harmeny may have made a recommendation following an internal investigation but the final decision on whether any action was to be taken or not would have to have come from Wishaw Social Work Department, who would have been splacing authority. I can't remember if they came to the school and spoke to would have made the final decision about what to do.
- 297. I had an excellent relationship with ______. He was one of the older boys, aged ten or eleven. He once challenged me to run seven miles around Pentlands Hill with him to raise money for charity, which I did. He was one of the most challenging children in the school. I am not inflating my own capacities but because I was pretty highly competent in dealing with aggression using solution focused approach, so I would quite often get asked to get involved as an intermediary and talk to a child.
- 298. I don't remember the actual incident of restraint.

HET-000000113

299. This document is a copy of the internal investigation carried out in Harmeny by Pauline Gilruth, who was the school social worker and KYN who was NR at the time. It is dated 10 March 2000. It is accompanied with a covering letter from Harmeny School to Wishaw Social Work Department, asking them if after considering the report, they think any further action or external review is deemed necessary.

- 300. Having read this document, it seems a much bigger incident than I recalled. Even my recollection about how it was reported was different because I had forgotten about RCB role. He was the group leader in Caroline Cottage. Reading the document has jogged my memory to an extent but not to that level of detail. It is a pretty detailed report and there were actions that I was to take from the report that were perfectly reasonable. I am not sure what I can really add to it. It seems comprehensive.
- 301. What I don't know from this report is what Wishaw's response was. The report was sent to them asking them to advise on how to proceed but their response isn't provided, and I don't remember what it was. I presume Stuart Ralley, who the report was sent to at Wishaw, would have responded because he was an actively involved social worker.
- 302. I've nothing to add to that particular incident except the overall context of my relationship with which was very positive. That doesn't take away from the seriousness of how I managed that situation. There were a few things that I should never have done. I certainly shouldn't have been alone with him and that alone would have negated the need to do anything other than a CALM hold. I'm struggling to know why I would have allowed myself to be left alone with except that I had normally, generally, a very strong relationship with him.
- was one of the children that I did individual therapeutic sessions with and I had a good rapport with him. Usually, if was showing aggression with another staff member, he would come away with me and the level of aggression would come down. I think that may have been what caused my over confidence that if I was on my own with him, that it would de-escalate, but clearly on this particular occasion, it was not the case.
- 304. I don't remember any follow up after this. I think stayed on at Harmeny after this incident but you would have to see his care records to see when he left.

HET-000000033

- 305. This is a one page memo written by me, dated May 2001 about the responsibilities of staff and management in Harmeny with regards to child welfare.
- 306. This looks to me like an extract from the staff handbook. It says 'ppsc/general' in small writing at the bottom, under my name, which is the Policy Practice Sub-Committee. This is the kind of thing that I would have taken responsibility to write and taken to the PPSC, and then it would have been put into the general policies handbook.

Extract of SCH-000000009 (pgs. 2&3)

- 307. This document is a letter from me to Edinburgh Social Work department dated 4th May 2005. It details the work which was done by Harmeny/ Save the Children in looking into the abuser David Brown, who worked at Harmeny from 1975-1984, before going to Albania where he was convicted of abusing children.
- 308. I did not work at Harmeny School at the same time as David Brown, but I was involved in looking into his actions, as can be seen in the letter.
- 309. I reported the information I was given by Mrs McInnes and Mrs Runcieman to Lothian and Borders Police. They both supported the charity that David Brown had established in Tirana Albania, through a church in Aberdeenshire, I think.
- 310. Thereafter, an inspector or Chief Inspector, I think, came and interviewed me and I passed on all the information I had. I also notified, through my board, Save The Children Fund, who managed the school when David Brown was employed. I passed on employment records that existed, which from memory were minimal. I have no recollection of additional information about the "adult young man" who is mentioned in the letter.

Inspection Letter: CIS-000010083 and SGV-001033705

- 311. The first is a letter dated 3 March 2010 from Val Turnbull at the Care Commission to me following an unannounced inspection of the school on 28 and 29 January 2010. Following the inspection, Harmeny is being required to ensure that: 'Within 2 months of this date... you must ensure that all staff employed in the provision of the care service who are required to register with the Scottish Social Services Council or another relevant regulatory body, are either registered, or have applied for registration.'
- 312. This was about the night-awake staff at Harmeny, who the Care Commission thought should be on the register for residential child care workers held by SSSC.
- 313. The second document is my letter to Anne McSorley at SSSC, dated 22 March 2010 where I lay out my arguments against the night care staff requiring to be registered with SSSC.
- 314. I think my response to SSSC and the Care Commission is pretty detailed and full. I can't add anything to that.
- 315. There was already a qualified member of sleep-in staff in each cottage who would be asleep. Plus there was a night-awake member of staff in each cottage who was unregistered. SSSC was stating that all night staff be qualified and I didn't agree with that.
- 316. We came to an interim agreement and I moved a member of our qualified day staff to be a night-awake supervisor, and they would move between the houses. This was a compromise between the two positions. This was in addition to the four qualified sleep-in staff and four unregistered night-awake staff who were already in place. This arrangement can be seen in the action plan, signed off by me on 29 January 2010 (CIS-000010163).

Provider Facing Notifications – Serious Injury to Service User: CIS-000010105

- 317. This is a Care Commission document in relation to a serious injury sustained by a child on 15th February 2010.
- 318. I have no recollection of this incident and would need to see the paperwork you mention to assist my recall.

CIS-000010174

- 319. This document is an action plan that has been signed off by Neil Squires, Chief Executive on 4 October 2010. It states:
 - 'Two Waking Night Supervisor posts were advertised and a recruitment process undertaken. Two successful candidates were appointed and subject to all checks being satisfactory, commenced on 1/9/10. One member of staff is fully registered with the GTC and the other with the SSSC.'
- 320. I retired in June of 2010 so this happened after I left and is signed off by Neil who took over my role as CEO. They clearly moved to taking on qualified night-awake staff after I left.
- 321. I feel this was one of the very few examples of when the national guidance and expectations actually went over the top in relation to the implementation by the SSSC of the guidance and regulations.
- 322. The issue was of safe care and being absolutely confident that the care and support arrangements for children in Harmeny were as good as they needed to be. That was my view.

The Doran review

- 323. As I was approaching retirement, Maggie Tierney, told me that Scottish Government were doing a piece of work which would take about six months, and asked if I would be interested in doing it. Maggie was the director of learning in Scottish Government and one of the over-seers of Harmeny School.
- 324. The piece of work was the Strategic Review of Learning Provision for Children and Young People with Complex Additional Support Needs. This was set by the learning executive within Scottish Government. It came to be known as 'The Doran Review.'
- 325. I left Harmeny in the summer of 2010 and started preliminary meetings on the Doran Review in around August or September 2010. Maggie had assured me that it would take six months but it was nearly three years by the time we got the final report out. It was a complex and incredibly challenging piece of work.
- 326. Maggie thought I was competent enough to do this piece of work.
- 327. Additionally, a central theme, which was not explicit at the start, was the funding of grant aided special schools, which Harmeny was. Maggie knew that my goal at Harmeny was to make it, through our own financial management, not reliant on government grants, so that the school could still run if grants ever changed. My position was that if the service was nationally needed and we were competent, then funding would not be an issue for a national resource for Scotland.
- 328. I was employed as an independent person by the Scottish Government to produce this independent report. It was not a Scottish Government report. I was commissioned to investigate this whole area, review it and report my conclusions to Scottish Government.

Purpose of Doran Review

329. The purpose of the review was as wide as the title suggests. What are the services for children with additional complex support needs? Here, we are talking about ADHD, autism and right up to very serious life threatening conditions and needs. We were seeking to review Scotland's approach within a policy framework and guidance that was available at the time. Thereafter, to make recommendations as to how the learning provisions for children and young people with complex additional support needs could be improved and developed. That also raised issues of policies and practices in the debates around mainstream versus special schools. The politics between local authorities and independent providers was at times difficult. I also concentrated a lot on parental views, as to what they were getting on the ground and how easy it was to navigate local approaches to ensure their child's needs were best met. Actual parental accounts of their struggles to achieve this were often very negative and conflicted with what local authority statements were about this.

330. The remit expanded to be quite a big remit, looking at learning provision across Scotland. The focus on funding and commissioning emerged from that, and that took in grant aided special schools, and whether there was a case for nationally funded provision, and how that could be commissioned. I believe that part is still being looked at.

Team selection

331. Maggie and I selected the team to work on the review. We identified all of the groups who would either, through the process, bring something to the table, or would have a view about our recommendations. We wanted to include everybody in the working up and process of the review. This was for the genuine reason of wanting to bring as much thought and consideration to the table of different and conflicting views. There were huge political divides across the country. We wanted to engage people from the ranks of local authorities and groups like COSLA, educational psychologists, association for principal psychologist, HMI Care Commission, SSSC, parental groups

and anyone else who had an interest. This approach self-identified the members we wanted.

- 332. In short, we identified who we thought were the key players that needed to be involved in the process. We then communicated with them and asked if they would engage and give us somebody who could work with us.
- 333. We set up working groups to look at specific areas and set their remit and allocated the relevant people to work on those. The membership of each group is quite representative. We tried to ensure we had somebody from all interested parties on the project board, but also on the working groups. I think we did a good job with that. They were all active groups. They weren't just turning up for meetings, they had work to do.
- 334. I think I had three or even four ministers during the time I worked on the review. Maggie moved on after some time.

Outcomes

- 335. I was very outcome focused, that this was not just going to be an Inquiry that went on for an overly long period of time with no clear objectives. The work was very high level and focused.
- 336. The work itself was carried out by setting up the working groups, setting the remits for them, reviewing them. We set up parental engagements and visited a lot of mainstream and special schools to see the good, the bad and the indifferent. We got a broad picture of the service provision across the country and identified common themes of the stakeholder interests. We then focused on the common themes to try and come up with ideas of what needed to be different and how that could be done.
- 337. I wrote the report and presented it to the Scottish Government. The final conclusion was the 21 recommendations that are in the report. The Scottish Government accepted all of the recommendations as having relevance. They detailed in their response that they were going to implement all of the recommendations that they could

and suggested that local authorities implement the ones relevant to them. This was to do with the relationship and functions of central and local government. There is a response document from Scottish Government to the report and it details what they can do themselves and what needed to be delegated to others.

- 338. Most surprisingly of all, when I had the final meeting with all of the protagonists around the table, they all accepted the recommendations too. I think the report was written in a way that it was hard for people not to accept it, even though it had quite high levels of critique of some systems, services and approaches. Even the grant aided special schools, who might have thought that their money was being taken away because we were promoting financially independent models, were on board. It was hard for anyone to oppose it because it made sense, even if it was going to be difficult and challenging for organisations to implement.
- 339. We extended the period that grants would be continued, so that the schools that receive grants will be cushioned for a lot longer. Part of that is because the National Commissioning Group hasn't concluded its work.
- 340. My involvement then finished and the implementation groups were formed, and I had no role in that. I think the commission group is still struggling but the other implementation groups have finished.
- 341. There is the ten year strategy from the Scottish Government, which initially started as a five year strategy.

Greatest impact

- 342. I think the conclusion and recommendations made by me in the report sum up my view.
- 343. Acknowledging the challenge that parents had in getting the right help at the right time in the right place for their children, when they were faced with potentially conflicting policies, was important. We supported the parental view that despite the good

intentions of authorities, it was a nightmare for some parents to try and negotiate and get the help that their child needed. The report raised that profile.

- 344. Then moving people away from the idea that only the mainstream could provide the services needed, was a big achievement, because that was a pretty fixed idea that was held by many. However, there were children for whom mainstream hadn't worked, wasn't working or was unlikely to work unless significant resources were implemented.
- 345. The mainstream presumption was potentially in conflict with Getting It Right For Every Child (GIRFEC) because GIRFEC meant there couldn't be a blanket approach. There could be a general aspiration but within that, we needed to look at whether that aspiration could apply to all children.
- 346. We cut though the previous idea that you could be either mainstream or special education. GIRFEC gave me the opportunity to frame this in the context of getting the right help at the right place at the right time. I brought that in under the Doran Review. Help needed to be timeous and in the right place, wherever that place was, and for it to not be determined by political or philosophical preconceptions.
- 347. There was also an acknowledgement that there is still a role for national provision, hence the National Commissioning Group. It shouldn't be in competition with local, mainstream or even local special provision. It should be part of the whole resource available to children and families across Scotland.
- 348. We also highlighted the training and qualification of special education staff because a lot of the teachers in special schools, particularly independent, weren't qualified to deal with the complexities of the work. Highly specialist staff are needed to meet the needs of the child.
- 349. Scottish Government acknowledged that the recommendations all made sense and I didn't have a rebellion from the key players. There was acknowledgement that things needed to move forward. Beyond that I have had no control over how fast or how slow it moves forward.

Final comments

- 350. My time at Harmeny spanned almost fifteen years and started nearly thirty years ago so my recollection of detail is sometimes non-existent or hazy. Where appropriate I would need to see full records, where they exist, to be sure of comments I have made in response to questions put. All of my comments in this statement were made in response to questions put to me by the staff of the Inquiry who interviewed me. The questions asked are not included in my statement.
- 351. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true.

Signed	
Dated	16 September 2025