Scottish Child Abuse Inquiry

Witness Statement of

Dr IPZ [redacted]

Support person present: No

1. My name is Dr IPZ [redacted]. My date of birth is [redacted] 1947. My contact details are known to the Inquiry.

Qualifications and Experience

University

2. BSc (Medical Sciences) 1968
MBChB (Bachelor of Medicine and Surgery) 1971
MBA (Masters in Business Administration)1992

Professional

MRCPsych (Member of Royal College of Psychiatrists) 1976
FRCPsych (Fellow of Royal College of Psychiatrists) 1985
Member of Scottish Association of Psychoanalytical Psychotherapists (SAPP) 1989

Career

Pre-registration posts, medicine and surgery, [redacted]
Resident in Psychiatry, [redacted]
Registrar in Psychiatry, Royal Edinburgh Hospital 19[redacted]
Senior Registrar in Psychiatry, Royal Edinburgh Hospital (REH) 19[redacted]

Locum (acting) Consultant in Psychiatry, Royal Edinburgh Hospital 1978/9 for approximately 3 months
Consultant Psychotherapist, [redacted] 1979

Secondments while a consultant with [redacted]

Clinical Services Manager, [redacted]
Clinical Director of Community Mental Health Services, [redacted]
Chief Executive Scottish Health Advisory Service, [redacted]
Member of Ministerial Committee on Free Personal Care, [redacted]
Review of Mental Health Services in Scotland [redacted]

Other relevant experience

[redacted]

Work with mental health advocacy/service user groups

Established an out-patient clinic for survivors of sexual abuse [redacted]
Member of Development Board for a Scottish Mental Health Service User Group, Voices of Experience (VOX)
Trustee of VOX
Director of [redacted]
Member of European Patients Forum
Advisor to Voluntary Association [redacted] (service user and carer group) [redacted]

Other

Board Member, Richmond Fellowship, Scotland
International Association for Forensic Psychotherapy (Board Member)
[redacted]

Moved from direct clinical practice into management, [redacted]
Retired from NHS [redacted]

Awarded [redacted]

Royal Edinburgh Hospital

3. I was a trainee doctor in psychiatry at the Royal Edinburgh Hospital from 19[redacted] until 19[redacted]. I joined as a registrar, rather than a senior house officer (the entry level for specialist training), because I had already undertaken a couple of years of training in [redacted]. After two years as a registrar, I was appointed as a senior registrar (the highest level of training) in 19[redacted].

4. In my final three months as a senior registrar, I was "acting up" as the locum Consultant in place of Professor Walton, who had unexpectedly gone on sabbatical.

5. I am asked to recall the physical set up of the hospital during my time there. The Royal Edinburgh Hospital services were provided on two main sites in Morningside; the Royal Edinburgh Hospital/University of Edinburgh and Craighouse Hospital which accommodated long stay patients.

6. The Acute Admission Wards (3-6) were in the Andrew Duncan Clinic section of REH. The services were 'sectorised' geographically i.e., each ward served a different sector

of the city, so that the patient's address would determine the ward to which they were admitted.

7. Specialised services for intensive care, younger people, psycho-geriatrics and alcoholism were on the REH site.

8. The Professorial Unit was also in the Andrew Duncan Clinic, Ward 1 run by Professor Walton and Ward 2 by Professor Carstairs. Admissions to these wards was at the discretion of the Professors and included neurotic and personality disorders.

9. A third ward connected to the University was the Brain Metabolism Unit, funded partly by the Medical Research Council.

10. Child services were provided at the Royal Hospital for Sick Children. In-patient psychiatric services were provided at the state hospital in Carstairs.

Staff structure at REH

11. The services were run by the Physician Superintendent (who would be akin to today's Medical Director) and the Chief Nursing Officer (previously Matron). Academic departments were run by the Professors.

12. The Royal Edinburgh was a prestigious site and well-resourced at that time. There was a full range of clinical disciplines: doctors, nurses, psychologists, occupational therapists, plus a social work department.

13. I am not sure of the numbers of trainees at the REH at the relevant time. I would estimate there to have been twenty registrars/ senior house officers and ten senior registrars.

Hierarchy

14. The Consultants were organised by the Physician Superintendent. We were told that the Consultants were responsible to the Secretary of State for Scotland, and as a trainee you were responsible to your Consultant who was your line manager.

15. There was a distinct hierarchy and deference to authority at the REH in the 1970s and I think this was the norm at the time in other hospitals. My impression is that things have moved on since then. As a trainee in the 1970s, your Consultant's advice was to be followed, and there was certainly an assumption that they knew best. They were in charge. I think it would have been very unusual to go against your Consultant's orders.

16. It was very hierarchical, not just within medicine but between all the disciplines. There were distinct and different roles and responsibilities for the nurses, social workers, psychologists and us. The hierarchy was clear to see. The Consultant, even though he didn't line manage the nurses, social workers and psychologists, had absolute overall responsibility for the patients.

Personalities

17. I am asked about the various personalities of the Consultants within the REH. Some listened to patients and staff, paid attention and were very involved in training and in looking after patients. Others less so. I never really got to know them personally because I only dealt with them in the professional role and not socially, so I can't say more about their personalities.

Training

18. The training programme was based on six monthly rotations to try and get an experience of the whole of psychiatry. The rotations for registrars would start in August

and February. As a senior registrar, you might stay in a ward longer and would start to focus more on one specialty that you hoped to move into as a Consultant.

19. At the time there was a psychiatric tutor who was responsible for organising all the different training and rotation placements. Trainees didn't get to choose their rotations, but it was worked out so you saw as full a range of psychiatry as possible. Usually the first rotation as a registrar was in acute general psychiatry. One of my placements was at the State Hospital in Carstairs, the only forensic training I received. I wasn't allocated Child Psychiatry and the Young People's Unit.

20. I would have had a rotation in Ward 1 when I was a registrar and another rotation in Ward 1 when I was a senior registrar.

21. While training as a registrar, there was academic training as well as clinical training. Four days a week were spent in a ward or out-patients. One day was spent in the university department attending lectures. There you would learn the academic background to psychiatry which led to two sets of national exams organised by the Royal College of Psychiatrists (RCPsych). These had written and oral components.

22. During registrar training, you also had to do on call work for the whole hospital, staying in overnight accommodation on site to provide clinical cover. This worked out to be roughly one night in three. As a senior registrar, you would not be required at the hospital overnight but would still be on call from home. The consultants only got called out of hours if there was something really significant.

23. At that time, psychotherapy was not a formal speciality within the NHS. It was a new treatment approach. 'Talking therapies' only started being developed in the NHS in the 1970s. It became a specialty in the early 1980s and formal training requirements were laid down by the Royal College of Psychiatrists. Before then, a Consultant in this field would have been known as a Consultant Psychiatrist with a Special Interest in Psychotherapy.

24. A group of us also formed a learning forum in which we did some reading and had discussions about psychotherapy. This was while we were training for membership of the RCPsych so it would have been around 19[redacted] or 19[redacted]. This group was intended to enhance our knowledge of psychotherapy and expand upon what we were learning from Professor Walton and in our academic lectures.

25. In addition, I enrolled for external formal training in psychoanalytic psychotherapy at the Scottish Institute of Human Relations, which lasted for four years. It involved weekly lectures and supervision of work with two patients undertaking psychotherapeutic treatment three times a week. I had to undergo personal psychoanalysis. All of this was undertaken in addition to my full-time work at the REH. I completed this training in 19[redacted].

26. Such additional training has since been made mandatory by the Royal College of Psychiatrists as a component of Senior Registrar training to become a Consultant Psychotherapist.

27. [redacted] we set up a group for female staff of several professional backgrounds. We talked about various matters, such as how best to deal with the way in which some patients (and some staff) would approach interactions with female doctors.

Developments in psychiatry in the 1970s

28. There was an increasing conflict about methods of treatment within psychiatry at the time. Professor Walton was interested in psychotherapy and less so about physical methods of treatment – drugs and Electroconvulsive Therapy (ECT). Traditionally, psychiatrists understood that all mental illness was due to brain metabolism, but now the newly developing psychotherapy perspective put emphasis on seeing people as complex individuals whose current and past life experiences contributed to their illness. "Talking therapies" became advocated.

29. In the 1960s and 1970s, anti-psychiatry views were gaining hold in the general population. Within psychiatry, these points of view were also gaining ground. There was a sense that drugs dealt with symptoms and improved behaviour but could make patients very drowsy and there were lots of side effects. Psychotherapy started to gain acceptance. But it was in its infancy and mistakes were made. In the last 50 years, like with all branches of medicine, there has been development and progress in psychiatry. This applies to both drug treatments and psychotherapy.

Ward 1

Daily routine

30. I am asked about the daily routine during my rotations in Ward 1 where Professor Walton was the Consultant in charge.

31. There was a ward round every day. Most disciplines would be there but probably not psychology because they were in a different department. It was mainly the doctors, nurses and occupational therapist. My recollection is that Professor Walton would normally attend the ward round and would also have weekly review meetings about individual patients where the social worker would attend.

32. Every weekday would begin with a group therapy session for every patient in Ward 1. My recollection is that the group would usually have no more than 18 patients.

33. The group session with the patients was taken by the registrar or senior registrar, apart from on Thursdays when it was taken by Professor Walton. Nurses were also present during the sessions to provide support and offer their input. The doctor leading the session was there to help foster discussion and explore issues that would arise in group session. The patients talked about their problems and themselves.

34. The group work gave patients an opportunity to learn from peers on a more open basis than perhaps they would feel in one-to-one sessions with the doctor. They would learn

coping mechanisms from each other. This is now an established approach as part of psychotherapy inpatient and outpatient treatment with its own specialist training, which has developed in both theoretical and practical terms and is standard psychotherapeutic practice.

35. Patients were encouraged to be open about all aspects of their lives within the confidential boundaries of the group, and this included sexual feelings and experiences. In the 1970s, sexuality was considered to be something to be more expressive about than people had been in the past. Medical students were being shown explicit films showing different groups of people having intercourse so they wouldn't consider it to be a negative thing. My view at the time was that it was positive to encourage patients to speak about aspects of their lives that they felt comfortable discussing in group therapy, but that the encouragement to discuss sexual feelings was not always appropriate. I was more comfortable with a focus on relationships, which should be the main topic under consideration.

36. Having reviewed the medical records that were provided to me in the context of this Inquiry, I think some aspects of the group discussions might have been inappropriate when discussing IW's non-physical relationship with another patient.

37. Once a week, there would be individual therapy sessions for each patient and we would pick up on anything which came up during the group session. The role was to give follow up support.

Professor Walton

38. I am asked how Professor Walton was regarded by other people. He was regarded in different ways by different people. He was quite a controversial individual. He stood out for several reasons. He was passionate about psychotherapy and about patients and trainees. He subsequently worked in medical education at an international level. For him, psychotherapy was the most important aspect of psychiatry. His previous speciality had been alcoholism where that would have been highly appropriate.

39. With his strong advocacy of psychotherapy rather than biological treatments, it seems to me that he was seen as more avant-garde and anti-establishment than his Consultant peers.

40. The other thing that stood out about Professor Walton was that he was a cultured man in the arts as a whole but particularly in terms of modern art. He and his wife (the Child Psychiatrist, Dr Sula Walton) amassed a large collection which, when they died, was given to the National Galleries of Scotland. He was also well dressed and articulate.

41. I am asked if I knew Professor Walton's wife. I only knew her through lectures. I probably met her a couple of times when we were invited to their house. It may have been to see some of their art collection. I never met her on her own.

42. The other side of Professor Walton was opinionated and powerful. He didn't have any doubts and reservations about the medical advice he would dispense. His views were accepted because he was a Consultant and Professor.

43. I respected him in the early years of my training, so I may be overemphasising the respect he had from others at that time. Other psychiatrists who didn't think there was a real value in psychotherapy probably didn't respect him as much. I admired Professor Walton because he seemed to have a genuine interest in hearing from the patient. He was anti-stigma. I considered his emphasis on talking therapy to be forward-thinking, holistic and empathetic. That is not to say that I agreed with every aspect of his approach. And I understood the vital role played by drugs in many instances.

44. On reflection, I think Professor Walton over-idealised psychotherapy and used psychoanalytic theory excessively to inform work with patients in a very different context and time.

Professor Walton's influence and leadership style

45. I am asked about Professor Walton's influence, but it is hard to know in retrospect.

Ward 1 was Professor Walton's patch, it was his creation, his baby. Non-trainees visited from many places to learn from him. Ward 1 had a high profile.

46. I do not know how Professor Walton led the university side of his work. He had a dual appointment and on the academic side he was a Professor which gave him even more prestige. In terms of his leadership of Ward 1, he led very firmly. He was very involved, more so than any other Consultant, and this was appreciated by the trainees who were sometimes out of their depth, particularly in psychotherapy because it was not yet a psychiatric speciality and in that respect it was somewhat in its infancy. It was - and is - a difficult discipline. Psychotherapy depends so much on what you, as the doctor, say to the patient. You have to listen to your patient and really take it in and respond in a helpful and meaningful way. This is not quite as black and white as prescribing a drug for a particular illness.

47. There was a clear sense that Professor Walton was an authority on such talking therapies. On review of the records provided to me in the context of this Inquiry, I can see his influence over me and the whole multi-disciplinary team in that we were all following his overall guidance and agenda with this particular patient.

48. Professor Walton's clinical advice in respect of patients in Ward 1 wasn't all negative and this is part of the dilemma in reflecting on his leadership and influence. He had issues and difficulties but on the other hand he offered a lot. One of the striking things looking back and trying to think why I regarded him as okay for the first year or two was because he did visibly help patients and they did get better. For example, he specialised in anorexia nervosa for people over eighteen and in some the weight gain and the capacity to carry on was quite striking and more so than in lots of places where there was an emphasis on force feeding. In that sense he had a lot to offer and you wanted to learn from him.

49. I am asked whether trainees slavishly followed Professor Walton. I would say that trainees followed their Consultant's direction. Personally I did not think we were "slavish", but I accept that our enthusiasm might make it seem so. We thought

Professor Walton was an interesting individual who was saying the right things and we could see that patients in his care were often getting better.

50. Our relationship with Professor Walton changed over time as the trainees became more experienced. I learned that what he was saying was a distorted, historic view of psychotherapy. I am not sure how much our behaviour changed but there was a big change in our attitude towards him in the latter stages of my training. We probably questioned him more because we were more experienced and able to present alternatives to him. Previously we might have thought some of the things he said were odd but he would always assure us it was the right answer. I didn't ever feel confident that my gut feeling about a clinical decision should trump his apparent wealth of experience and proven success in this area. Although I became dubious about his advice, and I have a clear recollection of other trainees feeling the same way, I followed it.

Professor Walton's attitude towards me

51. I think I was favoured because I was keen on psychotherapy, unlike many. He did tend to like or dislike people (just as others did him). [redacted] This was a time in medical school when there was a limit of 13% female students.

Professor Walton's absence on sabbatical

52. I was the locum acting Consultant for three months at the end of my time at the Royal Edinburgh. I remember I came in to start work one day and I was told that Professor Walton wasn't there so I was asked to stand in for him. I was told that he wasn't ill but there were some complicated issues he had to deal with. I was told that I wasn't to worry and that he wouldn't be off for long. I can't actually remember him coming back.

53. In his absence, I was holding the fort. In that period I don't recall seeing him but looking through the records I can see that he replied to a letter I wrote during the period in which I think he was still on sabbatical.

54. During Professor Walton's sabbatical, a Consultant post at [redacted] became available and I applied and was appointed.

Challenges to Professor Walton's advice

55. I am asked if anyone ever challenged Professor Walton's clinical advice. I am not sure that I challenged him. I certainly queried some of his advice. I don't think this would have been the norm for other doctors in training. I think I was probably quite assertive with him, which is partly a reflection of my personality and partly because it was more commonplace to ask questions about the advice of senior doctors when I was training in [redacted].

56. I might have queried aspects of Professor Walton's advice but he was always confident about his decision-making, and I didn't feel I was well placed to take these conversations any further due to my comparative lack of experience. Not only was there a significant age gap, Professor Walton had amassed a wealth of experience in psychotherapy, having practised it full-time for many years. In contrast, I was a trainee doctor and this was one of several rotations I was undertaking in a number of aspects of psychiatry.

57. I can't say that Professor Walton ever took on board any of the challenges or questions trainees had. He was always very forceful and firm but did it in a polite way.

Retrospective review of IW's medical records 1967 - 1979

58. The records were essential in the completion of this statement to the Inquiry, given a time gap of 50 years. I was given confidential sight of IW's medical records (which include some nursing notes). They are very patchy and don't give an adequate record

for the circumstances of this review. In particular the absence of psychology and social work records made it impossible to gain a full picture.

59. IW had some treatment as a child and adolescent in South Africa, but came to Edinburgh (there were family connections) in June 1967 following allegations of sexual abuse of school boys during his time as a teacher in South Africa. He was referred to Professor Walton by a neurologist in Cape Town, where Professor Walton himself grew up and trained.

60. Subsequently IW had two admissions to the Royal Edinburgh Hospital:

- 13/6/67 until 30/9/67
- 6/6/75 until 7/8/75

Over this time he had continuing out-patient follow-up. The notes do not have full information but it seems he saw both Professor Walton and a succession of trainees. I understand from the records that I would have come into contact with IW for the first time during my rotation in Ward 1 in 1975/76 when he was an in-patient. I would not have come across him again until my second rotation in Ward 1 in 1978/79. I saw him as an out-patient, once according to the notes, between December 1978 until February 1979, when I left to take up my post in [redacted]

IW's diagnosis

61. I am asked to comment on his diagnoses at discharge.

1967 Homosexuality (liking for young boys) ICD 320.6
Character disorder: dependent type
1975 Acute alcoholism
Homosexuality (paedophilia)
Passive dependent personality disorder
1979 Out-patient only, no diagnosis recorded.

62. In 1967 I was still at medical school and unaware of the diagnostic categories. The diagnostic system then was very different from today. At that time the International Classification of Diseases (ICD) was used, now in its eleventh revision. It is more common these days to use the Diagnostic and Statistical Manual (DSM), in its fifth version. I am not competent to reflect on the diagnoses given to IW on the above dates.

63. The diagnosis of homosexuality changed in line with social change. It was decriminalised in Scotland in 1981 for consenting adults over 21. DSM removed homosexuality as a diagnostic category in 1987, and ICD in 1990 at the same time as WHO.

64. As regards to alcoholism there is insufficient data to confirm the diagnosis although it is highly likely. The classification of personality/character disorder is controversial and difficult so I can make no comment on IW's diagnosis.

Clinical assessment and treatment approach

65. The assessment seems to have been that IW was ashamed of his paedophilia, leading in turn to alcoholism, which worsened marital problems. The alcoholism also led to impaired ability to deal with his sexual fantasies and behaviour. His early relationship with parents was seen as relevant, especially with his mother.

66. The hypothesis appeared to have two parts. First, that improving IW's relationship with women, especially the sexual relationship, would reduce his attraction to boys. Secondly, his sexual feelings towards boys could be converted to non-physical encouragement and support. Perversely it was considered that having paedophilc tendencies could actually make you a good teacher. It was an optimistic viewpoint that over-valued psychotherapy and led to the drastic decision that IW should return to school and subsequently not be dismissed when the abuse took place again.

67. I am appalled that IW was encouraged to return to teaching. I accept that practices have changed, but even then the lack of safeguarding children was wrong. I take

responsibility for my part in not doing anything about Professor Walton's insistence that IW should return to teaching.

68. Apart from this, most of the assessment seems reasonably accurate, but as far as can be seen it strikingly misses any risk assessment concerning the child abuse. Today, risk management would be considered an integral part of the work. To support and encourage him to work closely with children would be considered completely unacceptable now.

69. Instead of targeting this as a significant part of IW's personality requiring urgent attention and ongoing monitoring he appears to have been treated in a non-specific way by individual, group and marital therapy. He seems to have benefited in terms of self-esteem and improved relationships, which is good but far from enough. The key issue is not the good that was done, but what was *not* done.

70. I think the difference in time is highly relevant. It is 50 years on. Treatments and attitudes change and services develop. In the 1960s and '70s there was little alternative treatment available except possibly oestrogens to reduce sexual drive or aversion therapy to link thoughts of boys with very negative images and experiences. IW was placed in an inpatient psychotherapy unit with a range of staff with differing psychotherapy skills but no experience (presumably) with sexual deviation, child abuse or the criminal justice system.

71. While the Consultant must take overall responsibility for this neglect, it seems from the notes that the multi-disciplinary team went along with it. Nowadays one would anticipate the social worker having a key role in the contextual aspects including child protection issues, but there is no evidence of this in the notes except her being engaged in marital therapy paired with a doctor.

72. One key member of the team was the psychologist albeit he did not work directly on the ward. Although a focus on paedophilia was not part of the overall treatment plan, it is mentioned in the notes that working with this aspect was delegated to the clinical psychologist, who was skilled in behaviour therapy. Although referred to several times,

there is no record of this. All that I could find was a letter from another psychologist showing the result of testing which showed that IW's positivity towards images of women had gone up, while his interest in boys had gone down.

73. Information about what was happening in the behavior therapy would be crucial in checking progress and informing decisions. Psychology notes were held separately in the department, not in Medical Records. I am advised by the Inquiry team that these notes have not been able to be located.

Challenges to Professor Walton's approach with IW

74. I can recall one occasion when I raised a query with Professor Walton regarding the treatment. IW was the only patient I have ever treated with paedophilia. A patient with IW's diagnoses was not a patient that would normally be treated in Ward 1. He would be treated in Forensic Psychiatric, if at all.

75. IW made me feel very uncomfortable and treated me in a way I didn't like. He clearly sexualised me and made comments about my make-up, my hair and my nails during one-to-one sessions. I became very anxious, confused and upset. I found it very difficult to deal with. I told Professor Walton that I was struggling because of this behaviour. I asked if I should change the way I dressed and how I should stop it.

76. Professor Walton told me that this behaviour was really good because he wanted IW to develop his sexual interest in women and that this behaviour was a good sign. Professor Walton's thesis, which probably wouldn't have been seen as too wild at the time, was that you dealt with IW's problem by helping him get more involved in what would be considered normal sexuality, in particular relationships with his wife and women in general. He said that the main part of therapy was getting IW away from his interest in boys and showing he was less anxious and threatened by women. The fact that he was getting sexually interested in me was therefore a good thing and it was getting results. Professor Walton told me that I shouldn't change the way I dressed or anything else.

77. I felt really disturbed by this in two ways. First, I wasn't being heard as a trainee or as a woman. In fact, it was worse than that because Professor Walton told me that I was completely wrong. It was demeaning and not helpful to me and probably not to the patient. If Professor Walton thought this was right and that it was positive then I thought perhaps the whole method was wrong. Secondly, it brought into question the goal of encouraging the development of sexual feelings towards women. It seemed to me that it was not about healthy sexuality that was emerging. It would not be a cure for sexual feelings about boys.

78. What I would have liked from Professor Walton was a bit of sympathy and understanding, a bit of anger along with a promise from him that he would deal with it, and reassurance for me. I simply did not have the training to cope and did not have women peers to share the problem with.

Review of my written input in IW's medical records

79. In Section 3 of the medical notes on page 4 is a progress note which I wrote and it is indicating that this is my first interview with IW. This is dated the 2 July 1975, and this would have been during my first rotation in Ward 1 when I was a registrar. Following this rotation, I would not have seen IW again until 1978.

80. Section 7, page 1 - 8 are clinical notes which relate to the transfer note dated January 1976. This would probably have been when I was leaving this rotation in Ward 1 and he was transferred to the next trainee who was taking over from me on their 6 month rotation.

81. I understand from the records that the latest contact I had with him is at Section 2 on page 9. This is a letter from IW dated 31 January 1979 following his appearance at court for drink driving. There is talk of a "minor sexual offence" having "cropped up" and suggested he could see me again.

82. In Section 2, page 3, there is a psychiatric report, dated 29 December 1978, that I wrote at IW's request to his solicitor in relation to IW being charged with drink driving.

I wouldn't normally write and interfere with things like that unless the court asks. I would certainly not ask for anyone to be sentenced lightly now if I was asked. I said that he suffered from alcoholism and should get treatment as well as/instead of punishment. This letter would not have been written without discussing it with Professor Walton. I think this was towards the end of his time when he was on a sabbatical. Looking back on it now, it was a mistake to write the letter and to offer this view.

83. In a subsequent letter, I sympathised with him for getting a 'hard' sentence. I do not remember any of this. Professor Walton sent a letter praising my report as "most admirable" (Section 2, page 7). It puzzles me now because I thought Professor Walton was on sabbatical at that time. I doubt I would have supported IW in this way without discussing it with the Professor.

Input from IW's family

84. I am asked about the apparent criticism of Mrs Wares and dismissal of her and her GP's concerns. This seems to be the opposite of one of our core values: to treat people and their families with compassion and respect. Being able to listen is after all central to psychotherapy. There were complicated marital issues (not surprisingly), and we seem to get caught up in this. She was not supported. Indeed from the notes it feels as if she were being blamed. This is awful. Not only did we stress a woman already under stress, but we failed to respond to vital information about her anxieties. I can't rationalise it or excuse it.

Reflections on child protection

85. I am asked whether I was surprised at the time at the absence of child protection. Puzzled rather than surprised, although I wouldn't have known the term at the time. I had never treated a paedophile before and accepted that the Consultant and team knew best. I can't remember it being discussed. I think patient confidentiality was seen as paramount. Reporting wasn't mandatory in any way.

86. At the time, I think there was a general lack of consideration given to child protection. For example, I recall thinking it was unusual that there seemed to be very little, if any, thought given to the impact of psychotic patients' illness on their children when I was working in other wards. In that context, I maybe wouldn't have been surprised at the absence of consideration given to child protection in IW's case.

87. Overall the focus was on other aspects of IW diagnoses and I don't recall much about the detail of his abuse of children. I don't remember discussion with Professor Walton about whether IW should go back to school, but it seems impossible that I wouldn't have raised it. Professor Walton made it clear and it was just accepted that IW would go back to school and that it was really important.

88. I think I had concerns at the time. In practical terms, I don't know what I could have done differently back then. Looking back now I might have gone to the Physician Superintendent who organised the placements or possibly the tutor, but it wasn't really the done thing for Consultants to criticise other Consultants unless it was really clear. Sleeping with a patient might be an example of this. Looking back now, I suspect that there was some concern around the hospital about Professor Walton. Perhaps an approach to the Physician Superintendent would have been received better than I would have imagined at the time.

89. I wish I had more recollection about my interaction with Professor Walton and I would love to be able to say that I put my foot down and that I had taken steps or even left the unit, but I didn't. I honestly can't see how I would have been able to in terms of how things were but this doesn't help my sense of shame about it.

90. It is not clear to me whether the psychologists were addressing IW's paedophilia. Because of the limited medical notes and the absence of the psychology notes I cannot say for certain. Professor Walton mentioned IW's paedophilia in the notes, so it was discussed, but the notes don't give a clear account as to whether there was more detailed discussion which was not recorded or whether it didn't happen. I don't remember after this length of time.

91. The message we were given was that psychology would deal with the "bad bit", so we didn't need to bother with the paedophilia. Our issue was about supporting the "healthy bit" and making the healthy bit more strong, hence the sense it was great that IW was getting sexual feelings for women. Although we were not instructed to address the patient's paedophilia as the primary concern, it was clear that Professor Walton was attempting to address it in his own way.

92. By the very fact that Professor Walton told me that on the occasion that IW made inappropriate sexualised comments to me, that his interest in me was progress, then I definitely felt that Professor Walton was treating his paedophilia. I accepted this at the beginning. Given the behaviour therapy attitudes and the training we had been given, it seemed a good idea to not just see the person as the bad bit of the person but also seeing there are good bits to this person and we could help him deal with it, understand it and not do it again. As a general approach, the holistic view of a patient is good practice, but obviously the particular approach in IW's case was wrong.

93. I wonder now whether there was police involvement in IW's case. He had been arrested at some point and whilst it wasn't particularly clear, I gather it was overt in the school and the parents were aware. I can't recall any police involvement in his case, and I think I would remember if there was because it would have been the only time as a trainee that I would have treated a patient where there was police involvement.

Adoption

94. I am asked for my views on the fact that IW was able to adopt a child. This took place before I was involved. It seems extraordinary now to consider. If I had been asked I would have reviewed the adoption agency guidelines and sought advice from the Consultant and Social Worker. My gut reaction would have been that it was abhorrent.

Current practice

95. I stopped clinical practice in 19[redacted] and so I am not informed about current clinical practice. I do know that knowledge has improved, partly due to the clamour about the failure to acknowledge the high prevalence of sexual abuse within and outside the family. Forensic Psychotherapy has become recognised internationally as a separate specialty requiring joint training in forensic psychiatry and psychotherapy. Attitudes have changed in society as a whole, and new services have been developed in a few places. How to spread this knowledge and practice will be a major task.

Concluding remarks

96. With hindsight the treatment provided to IW 50 years at the Royal Edinburgh Hospital was ill-informed and inadequate when dealing with forensic issues. He should not have been treated in a specialist psychotherapy unit with no experience of sexual perversion or criminal behaviour.

97. Ward 1 was on the whole a good service helping many people. IW did gain support and some improvement in relationships. Nevertheless the failure to recognise the severity of his problems and the failure to put any focus on risk assessment and child protection was abysmal. The consequent strong encouragement of teaching as a profession would these days be seen as appalling.

98. I am surprised at the apparent lack of inter-agency working, but that may have been the norm at the time. There is no mention of involvement of the criminal justice system. No mention of social workers with a key role in child protection, not even recognised formerly as a key concept at that time.

99. I recall Professor Walton having firm views about treatment of IW. I regret not feeling confident in voicing my queries and concerns in more detail at the time, although I am not sure that it would have altered the course of events, having reviewed Professor

Walton's involvement in getting IW back to teaching. Undoubtedly mistakes were made. I am very sorry to the people who suffered because of it.

100. It seems to me that the grave omissions and errors must also be viewed in the context of the time. I can't imagine that a patient like IW presenting today would ever be allowed, let alone encouraged, back into a role working with children.

101. 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..... IPZ [redacted] .....

Dated..... 11 August 2023 .....