Scottish Child Abuse Inquiry

Witness Statement of

IQQ

Support person present: No.

1. My name is Dr IQQ. My date of birth is 1950. My contact details are known to the Inquiry.

Professional Background

2. I was educated at Dumfries Academy then went on to do my medical degree at Edinburgh University. I was then house officer in Dumfries for a year. The first part of my psychiatric training was at the Royal Edinburgh Hospital from August 1975 to May 1979 and the second part was in Aberdeen from 1979 to 1981. I had decided after I qualified that I would like to return and work at the Royal Edinburgh Hospital as I had done a student placement there and enjoyed it.

3. In the first part of training generally you would be allocated in turn to a number of wards or departments. There were around six or seven placements on rotation. I did a year in general psychiatry, then old age psychiatry, then rehabilitation, then back to general psychiatry which was in ward 1, then old age psychiatry, then child psychiatry, then intensive care and forensic psychiatry then back to general psychiatry. The only specialty which I missed out on was learning disability.

4. As part of training staff were also sent to other hospitals in the Lothians.

Royal Edinburgh Hospital

5. At that time, for the training of psychiatrists, the Royal Edinburgh Hospital was at its zenith. We considered ourselves to be on a par with the Maudsley Hospital. The Maudsley, formerly known as Bethlem and Maudsley Hospital, was the premier academic psychiatric hospital in London. The Royal Edinburgh had good consultant staff and attracted trainees of a high calibre.

6. Psychiatric training is in two halves. The older half are the senior registrars and the younger half, which I was one of, were senior house officers and registrars. There is a natural progression from senior house officer to be upgraded to registrar. Most junior staff were more inpatient than outpatient based. Just like in general hospitals the junior members of medical staff run the ward. They do the admission notes and the discharge notes and routine ward work.

7. Just like in general hospitals the outpatients would often see a registrar rather than a consultant, and this was the same in psychiatric hospitals. My belief now, as a consultant, is that passing patients from junior doctor to junior doctor is inappropriate. This should be the job of senior staff. In my practice, as a consultant, junior staff would see outpatients for whom six months or a year timescale would be sufficient for their treatment whereas patients with longer standing problems I would keep to myself.

8. The Royal Edinburgh Hospital was split into two halves. There was the Royal Edinburgh campus and the Craighouse campus both in Morningside. The Royal Edinburgh campus had two ordinary admission wards in the Andrew Duncan Clinic. The Andrew Duncan Clinic was built to replace some of the older wards. In the professorial unit were two smaller admission wards run by academic members of staff. There were also rehabilitation wards and old age psychiatry wards in the older part of the hospital. On the same campus was the University department which was a six storey building. The Craighouse campus had an admission ward and some long stay wards for chronically ill patients. I never worked at Craighouse campus so don't really have an opinion on the staff or the structure there.

9. When I refer to the 'Department of Psychiatry', I mean people who are paid for by the university and have honorary contracts with the NHS. The Department is formally responsible for the bulk of the teaching and the majority of research. Research was generally conducted by academics although some clinicians do some research. Ward 1 and ward 2 were called the professorial unit and was funded by the NHS. It was informally called the professorial unit basically because the professors worked there. All the junior doctors were funded by the NHS.

10. Each ward within the Royal Edinburgh had either one or two consultants depending on the size of the ward. In the first year that I started there were two consultants in the ward. This was because it was one of the two main acute admissions wards with a high turnover. Junior staff comprised a senior registrar and a lecturer paid for by the University who had honorary senior registrar status, there were two senior house officers, which was my post, and two registrars. Each consultant had one senior house officer, one registrar and one senior registrar in his team .

11. Overall I would say the Royal Edinburgh hospital had hundreds of patients but I cannot give exact numbers.

12. Senior registrars had a more supervisory role and were more autonomous. They would cover day to day for consultants who were on holiday, although legally there would be cover from another named consultant. In those days senior registrars were given two half days to pursue another interest like research of their own. They weren't supervising the senior house officers and registrars on a formal individual week to week basis. It was more that they would be part of the ward rounds and would give advice on what to do or what not to do.

Staffing

13. There were two professors in the professorial unit at the Royal Edinburgh hospital. They were Professors Henry Walton and Bob Kendall. Professor Walton had a bias towards psychotherapy and Professor Kendall had a bias towards a more biological

end of psychiatry. Dr Peter Kennedy was a Senior Lecturer and he was more middle ground. Professor Walton retired directly from the Royal Edinburgh Hospital. Professor Kendall laterally gave up clinical duties and was the President of the Royal College of Psychiatrists. Dr Kennedy moved to York, in part for a change, then took on a medical manager role but gave that up and became the chief executive of three psychiatric units in York. The unit at the Royal Edinburgh was run very democratically.

14. The psychotherapy approach is based on talking with patients. There are many branches of psychotherapy including cognitive behaviour therapy which is more about thoughts, and psychoanalytic psychotherapy which is more about relationships. The biological approach of psychiatry is through the premise that major mental illness is largely to do with dysfunction of the brain. This is easy to see in dementia because the brain is physically deteriorating. To what extent this is true in relation to schizophrenia or bipolar disorder is not so clear.

15. I was unaware of any acrimony involved between Professor Walton and Professor Kendall. They looked at things from different perspectives and had different views and practised in their individual ways.

Professor Henry Walton

16. Professor Walton was from South Africa and had a very expansive way of speaking. The pass rate for post graduate qualifications in medicine is usually around fifty to sixty percent. I remember him telling me not to worry about my exam, and that I should treat it like I was presenting a case to him in a ward round, and if I did so I would pass. The pass rate in Edinburgh for post graduates was out of the approximately 30 doctors, 29 would pass, almost every year. This could be a reflection of the high quality of teaching and the high standard of doctors that the hospital managed to attract.

17. People either liked Professor Walton or they didn't. I am not sure if I have any justification for saying this but I think some people felt that he had his favourites. Maybe the people who didn't like him thought he had favourites or thought they weren't one

of his favourites. I got on very well with him, respected him and he got on well with me. I thought he was good for my training. Latterly, as a consultant, I developed a psychotherapy interest which perhaps had its origin in Ward 1.

18. Professor Walton led the department from the front. If I was a junior doctor and someone was admitted to ward 1 under my care I would take that person's medical history although occasionally the medical student would take the history. At the first formal ward round I would present the case to the rest of the team. Professor Walton chaired these ward rounds which were usually once a week. Professor Walton would ask questions of me and of the patient. Dr IPZ, the senior registrar in the ward, would do the same or ask me to explain things further.

19. If I had any queries or any issues I would generally approach the senior registrar rather than Professor Walton. The senior registrars were there every day so I wouldn't usually try and find Professor Walton to ask him anything but as the University department was very close he was easily accessible. The treatment we were able to give was fairly mainstream albeit in the context of a psychotherapy orientation. The academic department was very close too so there was no need to ask Professor Walton. Most of the time it would have been Dr IPZ whom I consulted.

20. Professor Walton was happy to listen to different approaches or different views from others which he wouldn't have a problem with. Nobody would approach him in a challenging way. Sometimes patients will act differently in front of a professor so he would be happy to hear if junior doctors had different interactions or experiences with them. The syllabus for the exam covers everything so Professor Walton's input was always towards the psychotherapeutic end of the spectrum.

21. All universities and academic departments have a head of department which often no one wants to do as there is endless bureaucracy. In my time at the Royal Edinburgh I don't think Professor Walton was ever the head of the department, Professor Kendall was the head. I don't really have a view as to whether Professor Walton had an impact on the way the department worked because he and Professor Kendall had their own views. Research carried out was towards the biological end of the spectrum which

Professor Kendall favoured. Professor Walton had more of a contribution towards the teaching side. Both sides were complimentary.

22. Professor Walton's approach to psychiatry was not followed slavishly by the junior staff. It was a general psychiatry ward where some people had illnesses like schizophrenia and needed appropriate medication for that. Some had severe depression and if appropriate they were given electro convulsive therapy if that was indicated. In addition there was an emphasis towards talking about things in a group setting. We took a holistic approach to decide the appropriate treatment. If Professor Walton's method of treatment wasn't working the treatment would be changed. All views would be considered.

Oversight

23. There was no oversight of the department by any external body. Consultants are not line managed on clinical matters.

24. The whole teaching side of things was very thoroughly overseen by the Royal College of Psychiatrists, not just the academic component but the actual teaching on the wards. The majority of clinical teaching was done by the NHS staff and the College was very powerful and could withdraw approval of a teaching programme. There was also the Scottish Hospitals Advisory Service which visited all hospitals. They were quite powerful but became somewhat emasculated latterly in my view.

25. The Mental Welfare Commission also visited hospitals both periodically and specifically if problems had been identified.

26. I knew Professor Walton's wife Sula but just really in the passing. I didn't have my child psychiatry placement with her. I occasionally saw Sula but just knew her at an acquaintance level. Her knowledge of me would have been through Professor Walton. She might pass me in the corridor and know who I was as someone who worked with her husband.

Relationship between Professor Walton and Dr IPZ

27. My impression was that Professor Walton and Dr IPZ got on very well together. His bias towards psychotherapy had a huge influence on her career. That being said there was also a psychotherapy service, primarily outpatient in the Royal Edinburgh with two consultants and a more formal part of psychotherapy training was under their supervision. In those days all 'would be' psychotherapists also undertook training outwith the Royal Edinburgh at the Scottish Institute of Human Relations. This involved personal analysis and long cases which were submitted to them as well as formal academic teaching. In terms of Dr IPZ's career development Professor Walton was an early influence rather than a role model as he was part of her more formal training as a senior registrar. Dr IPZ was a prominent psychiatrist but although he influenced her initially in her career, I would say that she outgrew him in terms of her training being more focussed and her career developed in other ways as well, like for example going to the [redacted].

28. I can't really comment on their professional relationship. I can't say I ever saw them alone together. Dr IPZ was a registrar in Ward 1 and in my time there became a senior registrar. I would say that from her choice to be there on rotation she had presumably approached Professor Walton as she obviously wanted to be more involved in the psychotherapy aspect of psychiatry.

29. I should say that nowadays there are six formal specialist areas of psychiatry, child, adult, old age, forensic, learning disability and general adult. These are the faculties of psychiatry. Then there are alcohol problems which is part of general adult psychiatry but had separate training. In my day there was no formal senior registrar training in psychotherapy. You had to do this yourself. There were placements which were biased that way and you were taught it at the Scottish Institute for Human Relations and your outpatients were supervised by two psychotherapists.

Dr IPZ

30. Dr IPZ was the senior registrar in the ward at the time. I got on well with Dr IPZ. Our paths crossed from time to time, she latterly became [redacted] of the [redacted]

Treatment of Iain Wares

Referral

31. The notion of sectorisation had come in a few years before I went to the Royal Edinburgh. This meant that if you were from a certain area of Edinburgh you would tend to be registered with a specific GP. People from specific areas and GPs would be referred to a consultant because each had specific 'patches'. This could be overwritten but this was normal practice. The Professorial unit was not sectorised so people admitted to that unit were generally referred to Professor Walton, Professor Kendall or Dr Kennedy, or admitted when the general admission wards had no beds.

32. Iain Wares was referred initially to Professor Walton by a professional acquaintance/friend of Professor Walton in South Africa. Professor Walton was asked if he could help this young man. Often people were referred to Professor Walton because of his method of treating by psychotherapy. Similarly people were referred to Professor Kendall because of his biological approach. All referrals must come from General Practitioner although sometimes there can be a cross referral from hospitals but this would still require the endorsement of the GP. Sometimes other referrals come from elsewhere, like in Iain Wares case from South Africa. This was relatively rare.

Yolanda Vitolins, social worker

33. Ward 1 had a social worker, Yolanda Vitolins, who saw Iain Wares with different members of junior staff who rotated every six months. This was when he was being seen with his wife Rosemary. There was thus continuity via social work but

discontinuity in terms of junior staff working alongside. Ms Viltolins was very experienced as a psychiatric social worker so having relatively naïve junior doctors wasn't in itself an issue in terms of continuity of care. Ms Vitolins was involved because Rosemary was having a very difficult time because of Iain Wares' drinking at that time. Historically, sometimes when a spouse, or equivalent, was having a difficult time the social worker attached to the unit, would see her rather than the same member of staff who was treating the patient, which may cause a conflict of interest. Ms Vitolins had been seeing Rosemary for a while so it was decided that two people seeing the couple would be appropriate.

My involvement

34. My involvement with Iain Wares was as an outpatient between April and September 1977. At that time some outpatients got passed on from one junior doctor to another. When I arrived on the ward I would have been given a list of a few patients I was to see as an outpatient as well as those being primarily based in the ward.

Iain Wares medical records

35. In the medical notes of Iain Wares within Section 7 on page 14 is the transfer note dated October 1977 and this explains my mandate together with Ms Vitolins. It states "*It is felt by Professor Walton that marriage keeps Iain away from drink and young boys hence the conjoint interviews with Yolanda*". Although this as documented was in retrospect this was the mandate I had been given in April 1977 and puts the other notes into context.

36. Within the records at Section 7 page 13 I can identify these notes as having been made by me. The dates on these tie in with the occasions I saw him and to the letters I wrote to his GP. On every occasion I saw Iain Wares accompanied by Ms Vitolins.

37. The first occasion I saw him was on 27 May 1977 but there are no notes as the details are contained within the letter dated 27 May 1977 sent to his GP. This letter is at Section 15 page 16. The second time was as per the handwritten note on the 31st May

1977 then as per the handwritten note on 21 June 1977. He failed to attend on 27 July 1977 for whatever reason. The 23 August 1977 is marked as not suitable, which I presume meant he said he couldn't come that day. I saw him again on 6 September 1977 and I have noted that he is much more settled. The final time I saw him was on 27 September following which I wrote a very short discharge letter on the same date. This letter to his GP is also within his records in Section 15 page 17. All these notes were made by me.

38. Within Section 10 page 1 are notes relating to his admission on 13 June 1967 and on 6 June 1975. The final diagnosis in 1967 is recorded as homosexuality. It is hard to be sure of the exact picture in this case. Psychiatrists in the UK use the International Classification of Diseases (ICD) which is a World Health Organisation (WHO) document. We are now on the eleventh iteration of this. I cannot be sure that we used this 45 years ago and if so how sexual deviation, for want of a better phrase, was classified. Looking at it through modern eyes, homosexuality is one kind of thing, paedophilia is another. I don't think nowadays people would use the term homosexuality in relation to a predilection for young boys.

39. People of heterosexual inclination in adulthood could have a sexual interest in wee boys or wee girls exactly the same as those with a homosexual orientation. It is not helpful to conflate the two. This is certainly not how it would be defined now nor indeed twenty or thirty years ago.

40. In 1975 the diagnoses were noted as alcoholism and sexual deviation. All I can say is that in the real world a clerk in the medical records office would probably have filled this in and not a doctor. He was admitted as an emergency because his drinking alcohol was grossly out of control. His wife was at her wits' end. I am not sure that alcoholism would be listed in the ICD nowadays and would probably be considered as pathological use of alcohol, or something like that. He didn't have fits, cravings or need alcohol in the morning, the things you tend to associate with full blown alcoholism. His drinking definitely was a major issue.

41. In relation to the diagnosis noted in 1975 as sexual deviation this is a very broad term and would have been filled in by a clerk in the medical records department. He/she would have read that he likes young boys so picked this as the simplest way of recording it. I was never quite sure what the purpose of the front page of the medical records was where these diagnoses were recorded. I suppose for someone who has been in and out of hospital on a number of occasions it is a quick easy reference to see whether the person has been in numerous times or if this is their first admission. There is very little that can be learned materially from that front page so I don't think these headings should be taken very seriously.

42. Given that I am thorough I would always manage, at some stage, to read the medical notes from cover to cover when dealing with a patient. But if I was looking to get the most important information immediately I would look at a previous discharge letter or discharge summary.

43. In Section 15 Page 18 is the discharge letter written on 8 March 1978 by Dr David Tong who came to Ward 1 [redacted]. His name does not seem to be appear otherwise in these notes. I don't know how much of the notes he would have read beforehand but on the day in question he would have discussed with Ms Vitolins, the social worker, how they would conduct the sessions, and he would have been given a summary of Iain's case by Ms Vitolins. They would have done all they could do to complete the task which was to make Iain's marriage the best it could which would be for the benefit of both of them in a variety of ways: the sessions would concentrate on the marital relationship but not on the alcohol abuse, or on his paedophilia.

44. Rosemary, his wife, was in her own way not a particularly robust lady but she was at her wits' end but wanted the marriage to succeed. She was never my patient, so I can't predict, but my guess is that had the marriage ended she would have felt lost. I don't think her world would have fallen apart I thought as Iain's might if their marriage failed. Saving their marriage was not the purpose of couple therapy but if the marriage was continuing then we wanted to see what we could do to make it as good as it might be.

Transfer Note

45. In Section 7 page 14 is the transfer note written in October 1977 which I did. You must understand that in the past, and before patient access to their notes, that doctors talked in very short hand to one another. I have described them as an odd couple, which is true because they were odd and had come from very odd backgrounds in the terms of parents, and the parents' relationship with each other and the parents' relationship to their children. I guess this was flagging up that this couple was not ordinary.

46. My next choice of words is interesting where I say that Iain Wares was a pleasant pederast and his wife a somewhat harsh and exacting woman. To put this into context whilst paedophilia is horrific in terms of the act and its consequences it is perpetrated by people who appear ordinary. Basically I think I was saying in short hand that despite his history of paedophilia with young males which might prejudice someone against him, in the actual consulting room he was a pleasant and open man. Again this was just flagging up how he may appear at interview. These are the sort of things that Ms Vitolins would highlight before an interview.

47. I described Rosemary as a harsh and exacting woman again, this refers back to the notes. There is a lovely phrase in the notes where Iain states he married his mother who was a similar harsh and exacting woman. To some extent Rosemary was brought up as a boy by a harsh and very demanding father. My comments are not a value judgement but simply to indicate what may happen in the consulting room. It might help other doctors meeting them for the first time to understand the nature of the interaction between Rosemary and Iain would tend towards her being harsh and exacting. Iain would generally passively accept Rosemary's behaviour.

48. In the next sentence it says that Professor Walton feels that marriage keeps Iain away from drink and young boys. This reflects what my mandate and Ms Vitolins' mandate was as I previously mentioned in the transfer note which was to keep their marriage off the rocks.

49. I have then said it may be that Iain would benefit from individual sessions. I suspect that was retrospective from me looking at his notes again in relation to my next comment that perhaps his inclination for young boys is too firmly ingrained to make this a worthwhile venture. Our sexuality is pretty firmly embedded within us all and tends not to change. What one does with people with very antisocial sexual deviation which they tend to act upon is to try and help them find a way to avoid actually acting it out.

50. I think the clinical assessment of Iain Wares overall quite simply was that he was quite a damaged man albeit with some real strengths. Part of that damage was a predilection for young boys. A combination of greater insight in his part and the adoption of a more traditional lifestyle by getting married might also contribute to having less predilection for young boys, but also very hopefully would make him less likely to act upon his urges. I have read through Iain's medical records twice. I cannot remember him as a patient, so my impression of the clinical issues and treatment is third hand, the thrust was more towards helping this man sort himself out and less towards a specific strategy to prevent him acting out his urges (see next paragraph).

51. Iain Wares was seen by clinical psychologists, who keep separate notes, and they did some behavioural therapy with him, but these notes are not within his medical records and so I do not have access to them.

Obligatory reporting

52. In my view the clinical assessment and the approach taken with Iain Wares was realistic. Nowadays the law demands that if we are aware of sexual abuse of children then we must report this to the police. Back then that wasn't the case. Whatever did happen, although not in the public domain, was already in the child's domain, the parents' domain and the school's domain but there is no record in the medical notes of Iain Wares or our telling the police anything. Likewise there is no note in the records of the police being told anything by the child, the parents or the school.

53. If as a doctor or consultant I was to accept someone now as a bona fide patient with problems and it then emerged that the patient had apparently sexually abused a child then the law says I am obliged to tell the police about it. That potentially ends our therapeutic relationship, I might still want to help him but he may not want me to because I had reported him to the police.

Child Protection

54. The legal position in the 1960s and 1970s as regards to child protection and psychiatrists sharing information from patients which might suggest they posed a real risk to children was that there was no requirement to report this to the police. It is very difficult for me to put dates on when things changed in this regard and in what way. I am guessing that around twenty to thirty years ago there was some good statistical work which showed that the incidence of child abuse in people who ended up as psychiatric patients was much greater than in the population at large. This doesn't establish cause and effect in any sense, but it establishes a potential complicating factor for the patient.

55. On admission a patient is asked lots of routine questions which may or may not relate to their condition but they would be asked anyway. It was proposed that on admission doctors would be encouraged to ask patients questions, in a tasteful way, about previous abuse.

56. With regard to patients who gave information that suggested they might pose a real risk to children in the 1960s and 1970s I have difficulty in answering from direct experience. Even back then if someone said they had murdered somebody doctors agonised and sought advice from the Central Legal Office for NHS employees and from the General Medical Council and would consult their defence union to seek advice on breaching confidentiality. I guess if they were satisfied that it was overwhelmingly in the public interest to report this matter then they would. I guess this would be after a very considered deliberation in a fairly short timeframe. This is pure conjecture because I never experienced anything like this. As far as I am aware back

then and even up to a few years ago there was no obligation to report anything. Breaching patient confidentiality without overwhelming justification can lead to sanctions from the GMC which could include loss of licence to practise, and therefore the end of a medical career.

57. In Iain Wares' case I don't remember child protection ever being discussed amongst my colleagues, nor could I find any reference to it in his case notes. It surprises me now, looking back in 2023, that this was the case but it didn't surprise me then because it wasn't a "Thing" in the sense of being a prominent issue in the public domain. "Safeguarding" was decades away.

58. My views on the fact that an individual who has accepted he has sexual feelings towards children and who has acted on those feelings, and was to start teacher training is bizarre. Presumably there were admission criteria in relation to teacher training and Moray House took him on.

59. To put it into context Rosemary was the daughter of a headmaster and her guess, possibly unsubstantiated, was that fifty percent of masters in private schools had sexual feelings towards children to some extent and provided they didn't act on those feelings then everything was okay. This was a throw away comment but that was her perception as the daughter of a headmaster so I guess what I am saying is that although this happened, child protection as a thing for people to take seriously, hadn't yet established itself.

60. In relation to Iain Wares moving into a school whilst admitting ongoing fantasies about, and then physical contact with pupils, again I find that bizarre. I presume that schools had criteria with regard to employment.

Approach taken by Professor Walton and Dr IPZ

61. In Section 13 page 1 the case summary states that Iain Wares was admitted on 6 June 1975 to hospital as a result of his excessive alcohol consumption and marital

disharmony. He was referred by Dr Bulmer at the Western General Hospital. He came in as an emergency and then whilst being treated the other material came out which is listed in paragraph 2 on page 1 in relation to his attraction to young boys he was teaching. It also mentions an incident where he had touched a boy prior to this admission. I find it very difficult to comment on whether the approach taken by Professor Walton and Dr IPZ in advising that Iain Wares should remain as a teacher at Fettes was correct. This was their view given in good faith. I am not sure I would have taken that view myself, and I don't think anyone would take that view now. I think it was very much that was then and this is now. It was a very unusual line to be taken but I would be very surprised if this was the only one that ever happened.

62. Section 15 page 11 states that in February 1976 Professor Walton contacted the SNR SNR to persuade him not to dismiss Iain Wares. I again find this somewhat bizarre. In Section 7 page 2 Rosemary Wares and the GP also suggested that Iain should either stop teaching or at least not teach pupils of the age that he consistently fantasised about. My interpretation of the notes suggest the GP was felt to be a bit extreme. If he felt so seriously about it what was there to stop him from going to the police? He also could have been in touch with Fettes. I am not sure what weight, if any, his criticism of Professor Walton or Dr IPZ should be given. He was a citizen like the rest of us, and had a professional relationship with Iain Wares namely as his GP. If he thought he shouldn't be doing something then there was nothing to stop him expressing that opinion to the relevant people or to Iain Wares himself.

63. In Section 12 Page 13 in June 1967 Iain Wares said when he was about fifteen or sixteen he had been involved with his sister when she was only ten. He describes it being just the usual feeling around the sexual organs. In Section 10 page 21 it details that in August 1967 Iain Wares said his fantasies involved girls and boys. Following on from this Professor Walton supported Iain Wares in adopting a child in 1973. In retrospect this seems bizarre but I have no first hand knowledge of this and find it difficult to comment.

64. I cannot say that the comments which repeatedly focus on Rosemary Wares by those treating Iain Wares is criticism and wonder if they would perhaps be better described

as observations. I cannot really make any more comment on this other than it was the impression I got. Psychiatrists make neutral observations on people, which is part of what we do.

65. In Section 2, page 3 there is a letter from Dr IPZ in December 1978 to his defence solicitor which I have read. Dr IPZ has stated that whilst drink driving is a legal problem she viewed it as also a psychiatric one. She thought it appropriate to involve him again in some psychiatric treatment to explore this. She hoped that this offence could be viewed as a symptom so that his sentence is as light as possible minimising further burdens to be dealt with in therapy. Again all I can say is that was then and this is now. Nowadays by and large people don't drink and drive but in those days many people did and didn't really appreciate the devastating consequences if they ran over and killed somebody.

66. In this letter there is no reference to Mr Wares' sexual interest in children but it does mention sexual difficulties and their inability as a couple to have a child of their own. I see no reason why his attraction to boys should be spelt out in this letter. I guess by mentioning his sexual difficulties it is saying sex is a big thing in many people's lives but she didn't go into any detail. He was drinking to excess and not surprisingly he was caught on this occasion. I can't think of any psychiatric report I have done where I would have gone into any great psychiatric detail. Similarly I can't think of any occasion when I tried to get someone off a drink driving charge.

67. Psychiatric reports on people with a mental disorder would normally suggest if there was any contribution psychiatry can give to make it less likely this person will reoffend. If you can't come up with an idea you should say so and let the law take its course. Psychiatry use phrases, not necessarily in drink driving cases, like *'should the court consider a non-custodial sentence I would be very happy to see this person as an outpatient to look at some of those background issues.'* It is not the purpose of a report of this kind to spell out things in any detail.

Current Practice

68. Bearing in mind that I retired from the NHS in January 200█ it is difficult for me to make any comment on how Iain Wares' case would be approached today. My knowledge of current practice is gained second hand through my work since 200█ with the █████ █████████. I was working at the time in a private ██████████ hospital just outside Edinburgh where I worked for four years. Myself and other colleagues, because we were working in a small private hospital, thought it would be a good idea to make sure we knew what we were doing with regard to the new Mental Health Act. This Act had just come into force so we ██████████████████████████████ █████████ We wanted to make sure that we were detaining and treating people legally. ███████████████████████████.

69. I can't say how Iain Wares' case, if it was presented today, would be approached. I can only think aloud in what I would do if I was in that position as a consultant. Today I guess I would be pleased to try and help out an old friend or acquaintance from South Africa. I would say to the patient that he must appreciate that I am constrained in what I can and cannot do and that if in the future I became aware of further behaviour of that sort then I would be obliged to report it. I would also say that if there was a question of some future decisions being taken about employment or whatever then I might be obliged to disclose this information. I would then ask the patient if he was still happy to work with me despite that. If the patient was well informed and thoughtful he might appreciate that and confirm whether he was happy to go ahead on that basis. It would be his choice if he preferred to work with someone else.

70. If Iain Wares presented today his diagnosis would be something along the lines of paedophilia. I think the current International Classification of Diseases (ICD) has subheadings particularly toward young boys so it would probably be something like that. He would not be diagnosed as homosexual which does not appear in ICD 9, 10 or the current ICD 11.

71. Nowadays Iain would not be treated as an inpatient. He would probably be treated with cognitive behavioural therapy by a clinical psychologist.

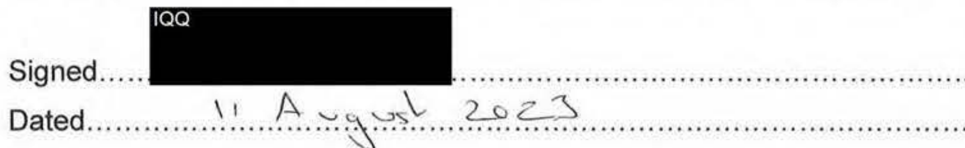
72. In Iain Wares case there is now safeguarding in place which I am aware of and if he presented there would be an obligation to report him now. I have no idea what training is given to staff nowadays in relation to child protection measures. If a teacher admitted such thoughts and behaviours, like Iain Wares did, then I would tell him that I was obliged to report him to the police. I would then give him the option of carrying on working with me.

73. I can't look back in hindsight and comment as to whether mistakes were made in relation to the treatment of Iain Wares. I am not even sure what is meant by mistakes in this context. Hindsight is not a helpful concept. I think that was then and this is now. The question as to whether mistakes were made is not a meaningful question. There are many players in this whole scenario. To think retrospectively that the hospital and two particular individuals out of the dozen or so doctors who dealt with him over the years, should have acted then as they would be obliged to act now is unreasonable.

74. We have a primary duty of care towards the patient. Other people have other primary duties. The primary duty towards Iain Wares was to find out if there was anything we could do to lessen the inclination or more importantly lessen the likelihood of acting upon it. The hospital tried to do that in good faith apart from his return to teaching. We had an obligation to him in terms of his excessive drinking and we had an obligation, if it doesn't sound too vague, to help him mature as an individual given his relative youth at the time (being in his thirties), which had been stymied by a very idiosyncratic background. These were the primary duties and I don't think we should confuse individual health with public health, these are separate domains.

Other information

75. 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.



IQQ

Signed...

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