**Scottish Child Abuse Inquiry**

Witness Statement of

**Alec SPENCER**

Support person present: No.

1. My name is Alexander Peter Spencer. I am known as Alec. My date of birth is [redacted] 1946. My contact details are known to the Inquiry.

**Background**

2. I joined the Scottish Prison Service (SPS) in 1972, having undertaken a post-graduate degree in criminology, during which time I visited prisons in England as well as a detention centre. Although I wanted to succeed in my career, I was not willing to walk past problems and would challenge the status quo.

3. My roles within the SPS were:
    - Assistant governor of Polmont Borstal from 1973 until 1975; I was in charge of a borstal wing and then the allocation centre; I was also a member of an organisation called 'Youth at Risk' whilst in this post.
    - Assistant governor of Perth Prison from 1975 until 1976.
    - Deputy warden of the detention centre and assistant governor in the young offenders institution at Glenochil Detention Centre and Young Offenders Institution from 1976 until 1978; I was second-in-charge of the detention centre and had daily oversight of it, along with general duties in the young offenders institution.
    - Deputy governor of Aberdeen Prison from 1978 until 1981.
    - I worked in administration and casework at SPS headquarters from 1981 until 1983, a role which included reviewing complaints by prisoners.

- Governor of Glenochil Detention Centre from 1983 until 1987; there were seven suicides in the young offenders institution and detention centre between 1981 and 1985; I was appointed to the Working Group on Suicide Precautions at Glenochil and acted as its secretary.
- Governor of Low Moss Prison as part of a temporary secondment in 1987.
- Deputy governor of Glenochil Prison and Young Offenders Institution from 1987 until 1989; I was second-in-charge of the complex and also acted as interim governor.
- Governor of Dungavel Prison from 1989 until 1992, during which time I introduced family visits and play areas; I founded and became chair of Families Outside; during the period 1989 to 1991 I also undertook some research into detention centres.
- Governor of Peterhead Prison from 1992 until 1996; I introduced programmes for sex offenders whilst in that post and the prison was awarded an Investors in People award; staff also won the top Butler Trust Award.
- I worked a SPS headquarters as an operational adviser on custodial contracts in 1996.
- Governor of Edinburgh Prison from 1996 until 2000; there, I established the first throughcare/links Centre and also built the first visitor's centre.
- Governor of Glenochil Prison and Young Offenders Institution from 2000 until 2001.
- Director of Rehabilitation and Care at the SPS Prison Board from 2001 until 2006; in that post, I was involved in the formulation of policy in relation to the rehabilitation and care of offenders, particularly in the areas of offender programmes and interventions, psychological services, risk and needs assessments, sentence management, education, skills and employability, vocational training, industrial work, social work, chaplaincy and families, addictions services, healthcare services, mental health, social inclusion and resettlement, and partnerships, research and analytical services. I also chaired the SPS Suicide Prevention Group, supporting and developing the ACT2CARE approach and monitoring our prevention strategies and our response to incidents.

4. In addition to my roles within SPS, I was chairman of the review group on the future management of sex offenders within Scottish prisons, which reported to the Minister for Justice in June 2002. In 1999, I published *'Working with sex offenders in prison and through release into the community: a handbook.'* I was the founder of *'Families Outside'* and its chair from 1990 until 2000. I was the vice chair and chair of *'Includem'* from 2001 until 2010 and am currently a trustee of the Lucy Faithfull Foundation and a non-executive director of Community Justice Scotland.

5. I was appointed as honorary professor, faculty of social sciences, University of Stirling from July 2005, a position which has twice since been renewed. I am an expert member of the university's ethics panel. I was chair of the Scottish Association for the Study of Offending (SASO) from 2006 until 2011, and Convener of the Scottish Consortium on Crime and Criminal Justice (SCCCJ) from 2009 – 2018. I acted as an adviser to the Scottish Parliament Justice (2) Committee on their Inquiry into Child Sex Offending from 2006 and 2007 and I have twice been a member of Audit Scotland's advisory panels on criminal justice system reviews.

6. I was Chairman of the Scottish Accreditation Panel for Offender Programmes from 2006 to 2010 and temporary Chief Officer for Tayside Community Justice Authority in 2010. I am also a public appointments adviser for the Ethical Standards Commissioner (ESC). I was asked by the Cabinet Secretary for Justice to review the issues surrounding the decision to send a particular prisoner to open prison conditions in the light of his subsequent absconding. That report was published by Scottish Government in 2009. I was also invited to provide evidence to both the McLeish Commission on Scottish Prisons in 2007 and 2008) and the Angiolini Commission on Women Offenders in 2011.

7. By way of introduction, I would offer a general observation: that prisons are by nature coercive; probably the most coercive institution in a democratic state. People do not want to be in prisons. There is deprivation of liberty and loss of individual agency. Prisoners are locked in cells, have to follow rules and routines which they may not like, are moved around the institution, and are imprisoned with others whom they may not like.

8. Prison authorities have power over inmates, can lock them up, order them to strip and be searched, may control by force, and punishments can place prisoners in separation. Separation involves being in even more sparse conditions, with loss of association with others. In the past, it was also possible to extend sentences through awarding loss of remission. Staff are responsible for writing reports on prisoners and for parole boards who read these reports, which can affect the length of time a prisoner spends in prison. While all prisoners should be treated fairly and equally, it is possible by their actions for staff to impact on how an inmate experiences his time in prison. Clearly when one group is dependent on another abuses can occur.

**Polmont Borstal**

9. My first post after training was as assistant governor at Polmont, which was a junior management post. I went there in the middle of 1973 and worked there until 1975. Initially, I was a governor in charge of a borstal wing, which was an accommodation unit. I was then moved to manage the allocation centre as its assistant governor, which is where people who had been sentenced to borstal first arrived. It was decided where they should be held because there were also open borstals at Noranside and Castle Huntly. People would be there for a while before being moved onto a borstal wing within Polmont or the open borstals.

10. While I was at Polmont the governor was keen that staff became involved with external community organisations. He suggested I became a member of Youth at Risk (Youth-At-Risk Advisory Group). This was run by the Countess of Mar and Kellie and involved adults (professionals such as social workers and youth workers, prison governor, police, psychiatrist and a BBC producer amongst others) visiting schools and youth projects to find out what young people thought. To listen and hear the problems from groups of young people – in the hope that problems might be articulated and ideas and solutions be identified. I was a member for a few years and the 'highlight' of the calendar was a residential consultation at Churches House, Dunblane, where young people, some from deprived areas and poor housing schemes mixed with children from more affluent backgrounds, some from private schools, to discuss a range of

problems which faced young people of the day (under Chatham House Rules). Subjects included unemployment, alcoholism, drugs and violence. Sessions began with a short presentation and then the young people talked and the adults listened, sometimes prompting with questions. Although there were a number of eye-openers and the sharing of experiences, emotional moments and the making of friendships, I am not sure that our reports added much to new learning, though we did contribute to a commission examining licencing laws and suggested development of some community projects. However, the young people involved were impressed that adults wanted to listen to what they had to say and perhaps benefited from being involved in discussions about current social issues. It also helped to give us better perspectives.

*Staffing structure*

11. There were a governor, deputy governor and a number of assistant governors. There were also uniformed staff, which included chief officers, principal officers and ordinary prisoner's officers. The staffing structure within SPS changed in 1987 with the introduction of the Fresh Start initiative. As assistant governor of the allocation centre, I was responsible for the management and running of it. There would also be a principal officer in charge, senior officers and basic officers. At that time, I think quite a number of prison officers were still ex-military. They were all men, although the borstal system did have female matrons. I think there may have been one for each wing so there was a single female member of staff in each of them.

*Arrival at borstal*

12. When inmates arrived, they would go to the reception area. They would be seen by staff. I think the first thing staff did was check that there was a legal warrant for the inmate to be there. We weren't as aware then as we are now about people who were more vulnerable or suicidal. Those sorts of markers and ideas developed later. People would try and look at whatever documentation came with a prisoner so that staff had a bit of an idea of the type of individual and whether they had had problems in other places. They would be given their borstal equipment and clothing. At some point, probably the next morning, they would be seen by the doctor who checked that they

were well. That person would have been an external practitioner who held a contract with the borstal and came in regularly. We did have other healthcare facilities. We had a forensic psychiatrist and psychologist. There was an education facility as well so we would get to know a bit about people.

*Daily routine in the allocation unit*

13. During their induction, inmates would come into the hall or wing and staff would show them the ropes. They would tell them what the routine was and what they had to do. In those days, the allocation centre was more regimented and routinized than later on in the sentence. Inmates would be woken up at about 6:00 am. They would have to clean themselves, wash, shave, tidy their cells. Like all prisons in those days, there wasn't integral sanitation. One of the first things they'd have to do in the morning was empty their pot if they'd used it during the night. They would then have breakfast before going off to work, education or physical training.

*Work*

14. Work included vocational training, so I think there were courses like brick-laying and motor mechanics. If there was work, it would be basic. I really can't remember the specifics.

*Education*

15. There was a head of education and some teachers. I think the teachers were probably on secondment from the local authority. I think most inmates were assessed for their educational achievement. Priority was given to those with literacy problems. Also, I think those who were keen to continue with their studies were welcomed as well. If anybody wanted to study a particular subject then I think that was possible. The quality of the education provided was good but basic. I'm sure that the teachers were dedicated. They were qualified teachers trying to help people with their literacy. They'd probably be people who would now be considered as special needs teachers. That sort of thing developed in the course of my career as we began to understand about

dyslexia and special needs, but that may not have been how it was described in the mid-seventies.

*Healthcare*

16. There was a healthcare team. There was a doctor who was a local practitioner contracted to come in every morning. He was the senior professional in the healthcare team. We also had nurse officers. At that point, they may not have been very qualified (and were trained as 'Enrolled Nurses'). There was a different accreditation system for nurses. They were staff who got involved in healthcare, but they wouldn't necessarily be nurses who came to work in the prison. There was also a psychiatrist and a psychologist who came in from time to time as well.

17. Inmates could request to see the doctor. Young people would be triaged by the nurse officers initially. They would decide whether the young person could wait to see the doctor the following morning. If it was something more serious, they might call in the doctor. If it was something very serious or urgent, they would have been taken to the local hospital at Falkirk. I don't think any inmates died during my time at Polmont.

18. I don't think there were any routine health checks after the initial check upon admission. On transfer to other establishments, inmates would also be seen by the doctors there the morning after arrival. There weren't regular dental checks, but I think the doctor may have looked in their mouths when they arrived at Polmont. If there was something irregular, I think they were referred on to the dentist. There was a room with a dental chair and an external dentist came in from time to time to see patients who had been booked with him. Medical records were kept and would have been held in the medical unit.

19. From time to time, myself and other staff would have been concerned about individuals who might have appeared to be depressed. We would have referred them to the clinicians. Doctor Fergus Stallard was the consultant psychiatrist and Ian Stephens was the clinical psychologist. I think Ian Stephens worked at Carstairs as well. Staff would pass on concerns to the medical team. Young people would then be interviewed

by the psychiatrist or the psychologist. If there were real mental health problems then inmates could be transferred to a hospital or to Carstairs. I can't recall whether that happened when I was at Polmont, but it has happened in my career on occasion.

*Visits*

20. Visits were allowed and arranged. I can't remember the amount of time that was allocated to visits, but I think it was less than would be now. There may have been some financial assistance for visits at that time, but it would have been a very tortuous process involving social workers. Arrangements and facilities have improved over the years. Visits were encouraged and families were encouraged to come and visit. At that point in time, visits were seen as a privilege and as something extra. For recalcitrant individuals, it might have been the case that visits were stopped. That may not have been a good thing because it might be that the family was what was required to try and improve things. I don't think visits were seen as something that had to be earned, but there was still a vestige of the attitude that if you didn't behave, you didn't get your visits. I'm pretty sure that visits were only withheld on rare occasions. Throughout my career, I was very keen on family contact and visits. Later on, I founded an organisation called Families Outside and managed to build the visitor centre at Edinburgh Prison with charitable money.

21. Social workers did visit inmates at Polmont. They only visited if they needed to. It was very much when there was a requirement to do so, for example if another report was needed or if there were issues with where a young person might live upon release. Not all parents were supportive and wanted prisoners back. If my recollection about borstal sentences is correct then they were subject to supervision for a year after release (the original borstal sentence was indeterminate for between six months and two years). Social workers were likely to visit prior to release in an effort to support them back into the community. When social workers did visit, they were able to speak to prisoners on their own. Occasionally I may have had cause to speak to a social worker if there was a particular concern about a prisoner but ordinarily their business was with their client. I can recall corresponding with social workers about inmates.

*Contact with families*

22. In those days, correspondence was a privilege. The potential was there to stop prisoners communicating by letter if they misbehaved. I think prisoners were allocated one free letter a week (postage paid by the borstal). The people they wrote to had to be approved by the staff. They couldn't just write to anybody. Staff would expect them to write to their families. Correspondence was read and censored. As part of the record keeping, lists were kept of letters which came and went.

*Leaving Polmont*

23. After a couple of years at Polmont and two different posts, I was moved to Perth Prison where I was an assistant governor in C Hall. It was a mixed hall. Prisons operated on a request system so prisoners could ask to see the governor the next morning. On one occasion, a prisoner who was about to be released came to see me He didn't want to go back to the workshop because he thought there would be some kind of ritual applied to a prisoner who was leaving. He wasn't keen on experiencing the ritual and I agreed that he could stay in his cell. I can remember the staff kept on telling me that the prisoner really should be going to the workshop. It was one of those tests of a junior manager, whether I would stick to my decision or give into whatever the culture of the staff was. These incidences were very trivial but part of understanding how to manage things. They were an indicator of what would happen if there was abuse or something else going on. I never walked past something. As a manager, if you saw something that was broken or a behaviour that wasn't quite right, you might not want to deal with it at that particular moment. But, if you walked past it, especially if you'd seen it, it signalled to others that it was okay. I left Perth Prison and was appointed deputy warden of Glenochil Detention Centre.

**History of detention centres in Scotland**

24. When I worked at Dungavel from 1989 until 1992, I carried out some research into detention centres. I was thinking about doing more extensive research so I have a lot

of documentation about detention centres. In my travels around various institutions, if reports and things were being thrown out I tended to hold onto them. I gave some of them to Stirling University library, but I still have many of them. When I did my research into detention centres, I saw files between ministers and that kind of thing at Register House in Edinburgh.

25. By way of introduction to detention centres, there had been discussion about detention centres in the 1920s and 1930s. The regime was a compromise between those who wanted to maintain corporal punishment and somewhat brutal deterrent regimes and those who wanted more reforming regimes. It was meant to be for people who hadn't got into trouble before, who were first time offenders and were to be given a brutal wake-up call. There weren't many of them around and most detainees had already been involved in criminal activity. It wasn't meant to be for people who couldn't undertake the brutalising physical programme. There was a whole range of people who weren't suited to it.

26. The first detention centre in Scotland opened at South Inch House within Perth Prison in 1960. It was a senior detention centre for youths between the age of 17 and 21. There had been talk at the time of junior detention centres for 14 to 17 year olds, but that didn't materialise. It was intended to be a separate establishment, but that didn't happen. The routine started at 6:00am and people cleaned, had breakfast and then did physical training and drill. By 1962, there were complaints about prisoners being beaten repeatedly, being subjected to treatment designed to break their spirits, not getting proper medical treatment and that seven youths had tried to commit suicide. I saw correspondence between the secretary of state and others. They wanted to keep it as low key as possible, but they needed to do something. They set up an inquiry, which was held by the local visiting committee. Two members of staff were proceeded against for assault at Perth Sheriff Court. They were both acquitted and the Scottish Office ended up reimbursing their legal costs. Detention centres ceased as a sentence in 1988.

**Glenochil Detention Centre and Young Offenders Institution**

27. Very soon after joining SPS I was appointed to Glenochil. At that time, it was a new young offenders institution which had been built next to an old set of coal board buildings, which became a detention centre. It was a big complex housing young men from the age of 16 to 21. There was a senior governor, a deputy governor, some in-between governors, assistant governors, then chief officer 1, chief officer 2, principal officers and officers. There were a lot of staff and a large staff structure. I was assigned to be the number 2 at the detention centre. I'm not sure how I was assigned, but maybe it was by the governor. As an assistant governor, I was also part of the management team for the whole complex. I'm not sure how people were assigned to different roles. Gordon Neave had been the governor at Perth Prison and was moved to govern the new complex at Glenochil. He picked people from around Scotland to work at this new institution.

28. I spent about a third of my career in that establishment. I returned as governor of the detention centre from 1983 until 1987 and was the deputy governor of Glenochil Prison and Young Offenders Institution from 1987 until 1989 before being posted there as governor from 2000 to 2001.

*Regime at the Detention Centre*

29. Glenochil was a fairly brutal and militaristic type of regime. By the time I went there in 1975 I suspect it was less brutal and militaristic than it had been. The regime was intended to be a deterrent and one of military type discipline, physical education and cleanliness. In the course of my research, I discovered correspondence that suggested, for example, that inmates would rise at 6:00 am followed by a cold bath, then physical drill from 6:30 am to 7:30 am before breakfast. That didn't happen, but that was what was being discussed before the detention centre was established. Some of the ideas were really abusive and brutalising.

30. Because it was supposed to be a short, sharp shock it wasn't possible to do anything reformative. In a sentence that was mostly three months, which with remission

effectively became two months, there was little possible by way of education. By the time people had come in and settled down it was time to leave. That meant it remained a strict military regime of physical education, drill and marching and cleanliness. I have provided two manuals from that time published for officers, entitled 'Drill Movements'.

31. There was a grading system, which detainees were encouraged to progress through. They got better wages and more privileges as they moved through the grades. Every morning, I had to see individuals to assess their grades. Inmates who were accused of breaking the rules would be brought before me.

32. After the evening meal, there was about an hour or two of recreation for detainees. There was TV, table tennis and the basics. I think there were still efforts to have some educational classes and bible classes in the evening. There was an education unit within the detention centre. I thzeitink classes were for those who really needed them. There were one or two classrooms. There was an education unit in the young offenders institution and teachers would come into the detention centre from there to do some teaching. Given most detainees were only there for an eight week period, there was time for assessment and a bit of support but that would really be it. If stripping cables or working in a laundry was training for life, then you could say that detainees were given skills or training to equip them for adult life. Otherwise, they were not.

*Healthcare*

33. The healthcare provision at Glenochil was similar to what I described at Polmont. There was a health unit located between the young offenders institution and the detention centre. If a young person needed to go to hospital they would be taken to Stirling Royal Infirmary. There was a visiting dentist and people could be listed for treatment. Records were kept of medical treatment received by detainees.

34. Both the young offenders institution and the detention centre were serviced by the same team of medical professionals. There was a psychiatrist, whose names I can't remember, and a psychologist, Professor Kevin Power. In 1987 I jointly authored an

article with Professor Power, 'Parasuicidal Behaviour of Detained Scottish Young Offenders,' for the *International Journal of Offender Therapy and Comparative Criminology.* Detention centre sentences were short so it was rare that detainees presented with mental health problems. If they did, they would be seen by the psychiatrist or psychologist.

*Visits*

35. Social workers did visit the detention centre sometimes. Inmates were subject to one year's statutory supervision on release, and with the potential for recall. Family visits were also facilitated, but there weren't many. The location of Glenochil caused difficulty in that regard. Laterally, organisations like SACRO organised buses for family members to visit. That was at the weekend so visiting during the week was hard. Taxis were expensive and there was no local bus in those days. It was very difficult to get to Glenochil from Stirling. People could spend hours travelling with young children from places like Aberdeen or Glasgow. It was quite a punitive measure for families as well. That was one of the reasons I got involved in forming Families Outside.

*Family contact*

36. Inmates were able to send letters home. Technology was starting to change. We recommended that there should be payphones. They were about to be introduced when I was at Glenochil. I think it may just about have happened before the detention centre closed in 1988.

*Article and photographs in Die Zeit magazine*

37. I have a number of black and white photographs of the detention centre which show a number of aspects of the regime at Glenochil, which I have provide to the Inquiry. They were taken by a photographer accompanying a German journalist, Reiner Luyken. Glenochil had become quite a known institution after the suicides in the early 1980s. The journalist visited Glenochil in 1984 to write an article about the detention centre regime. His article was published in the German magazine *Die Zeit* on 24th August

1984 and I have provided a copy of it to the Inquiry. The article was duplicated in the *Stern Newspaper* and I have provided a copy of that article to the Inquiry. I have a copy of the translation of the article and the title translated as, 'The Worst Place in Britain', which I have also provided to the Inquiry.

38. Much of the detention centre regime is illustrated by the photographs. They show detainees being given their sandwiches and tea whilst outside on parade, which was the practice as long as the weather wasn't too inclement. One of the features of the regime was inmates had to keep their cells clean and tidy. The floors had to be polished. Kit had to be folded and laid out in the correct way. Bibles would be used to get the edges straight. There are photographs of the cells showing chamber pots, bed blocks, folded clothes and detainees polishing their floors. There was a great emphasis on cleanliness. Everything had to be immaculate. There are also photographs of work being undertaken with the bumper cloth. They would strip telephone cables and put jigsaw boxes together. Detainees had to do work, but could also be given extra work as a punishment.

39. When it came to tidying cells and folding clothes, other inmates might help new inmates and show them how to do it. In the past, I heard and read that if things weren't done properly, staff would go into cells and rip up the whole lot. They would tell detainees to do it all again. That was fairly abusive and harsh. I'm not aware of that happening when I was at Glenochil, but I don't know whether I would have been aware of that as management.

40. There were a lot of changes of clothing during the day at Glenochil. Detainees had to change into their breakfast things in the morning, then their physical training clothes, then their work clothes. There are photographs of detainees doing physical training. It was very brutalising if you didn't want to do it and you were forced to do it. They had to climb up things, run and lift weights.

41. Some of the photographs depict the segregation cells at Glenochil. If somebody at Glenochil was felt to be at risk of suicide, they were put into a cell with cardboard furniture and a bible. They had to wear canvas gowns.

**Abuse at Glenochil**

42. In 1984 to 1985, I was part of the working group headed up by Derek Chiswick that looked into suicides at Glenochil. We received unsolicited evidence from a former inmate in the course of our work in the form of an audio recording. It was subsequently transcribed and I have provided a copy of the transcription to the Inquiry. The individual had been an inmate in 1968, two years after Glenochil had opened as a detention centre. He had been sentenced to borstal and had been serving his sentence in Barlinnie. For some reason, he ended up at Glenochil Detention Centre. He claimed that when he arrived, he got off the bus and was punched in the stomach. He asked why and was told that he had been leaning against the bus and that wasn't allowed. He claimed that staff, including medical staff, beat up, punched and degraded inmates with harsh treatment and physical exercise. He spoke of additional punishments involving physical exercise. His experience in 1968 was of a brutal regime with many staff involved in punching inmates. He didn't report that abuse at the time and refers to why doing so was difficult in the transcript.

43. There were no official records of any complaints from this time. When I carried out my research into detention centres in 1991, I discovered reports from the 1969 prison inspectorate. In those days, the prison inspectorate comprised of internal people and it was an internal report. It found that there were no problems at Glenochil and discipline was good. However, in 1972 the inspectorate recorded a discussion with the warden and chairman of the visiting committee which included, "Both assured me that recent incidents involving certain members of staff must be looked at in isolation and that there was no evidence to indicate that what is alleged to have happened could be interpreted as frequent practice." There is no indication what that was about, but two years later in 1974 the inspectorate recorded that "discipline is very much less rigid and militaristic than was formerly the case." I wasn't aware of these complaints of assault until I carried out my research in 1991. I wasn't aware of any allegations of abuse or assaults by staff when I worked at Glenochil.

44. I think the incident that I can recall occurred in 1987. I tried to obtain the date of the incident from SPS in advance of meeting with the Inquiry, but they were unwilling to

give me information about it. At the time, I was acting governor of Glenochil. Out of curiosity, I happened to ask why the chief officer's door had a covering over the small window slit in it when all the other office doors did not. I think there was a prisoner or somebody cleaning around that area. I asked him why the window was covered. He said that the chief officer did so in order that he could sit young offenders on his lap in his office without others observing. That practice was clearly not appropriate and was abusive.

45. The individual concerned was someone that I had known reasonably well. Since he was already of retiring age, I telephoned him at home and told him what I had learned. He did not deny what I put to him. I suggested that he ended his employment with SPS. I told him that since I now knew of him bringing young people to his office, I would have no alternative other than to report it to the police the following day if he was still a member of the Prison Service by that time. He submitted his resignation the following morning.

46. I took this action without knowing the names of any of the individuals involved and without there being any allegations. I did what I thought was appropriate at the time, but I didn't have the names of any specific people involved. There was no guidance about how I should act in such circumstances. My first duty was to protect those in our care. Without evidence of allegations it was unlikely to be something we could have acted upon further, except by reporting it to the police. It would also have had huge reputational consequences for SPS. Clearly I do not know if abuse occurred and, if it did, what abuse occurred, but I do know that the practice was inappropriate and unacceptable and, as a minimum, could lead to further consideration. As far as I'm aware, nobody came forward after the officer left to make any complaints or comments about him or anything he might have done.

47. If there had been a specific complaint about the chief officer then I would have reported the matter to the police. Although his behaviour was inappropriate, I couldn't say that abuse had taken place. I'm not sure what the police would have done if I'd reported it. They may have gone around asking people whether they knew about it. Staff might think that was unfair because it may have invited people to make complaints.

**Review of Suicide Precautions at Glenochil, 1984 – 1985**

48. I gave evidence at a lot of the Fatal Accident Inquiries into deaths at Glenochil. In one of the Fatal Accident Inquiries, a psychiatrist called Doctor Norman Kreitman suggested that the process of observations on inmates thought to be suicidal wasn't a very good one. He suggested that there should be a review of the way that things were managed. Faced with five deaths at that time, the secretary of state in the prison department thought that an inquiry should be held. The working group was established as a consequence.

49. I was a member and secretary of the review group headed up by Derek Chiswick. At that time, young people would be put into isolation and all that would happen was that they would be checked every fifteen minutes to ensure that they weren't trying to commit suicide. Fifteen minute observations were the strict suicide observations at the time in any prison. The photographs taken for the *Dei Zeit* article showed an inmate in isolation wearing a canvas gown. It was all designed to make it as difficult as possible for a prisoner to commit suicide. We felt that it wasn't a very good system. It really just made matters worse. The concern of the review group was that it was a very passive thing. We felt that there needed to be a more engaging, interactive and preventative way of doing it.

50. The Sheriff Principal presiding over the Fatal Accident Inquiry found that the system was good at preventing anybody from doing anything. There was nothing in the cells. Apart from going on a hunger strike, inmates just about couldn't kill themselves. However, it was an awful regime. Those under observation couldn't even keep a pen to write a letter because a pen could be used as an implement for self-harm. These kind of practices persist in prisons and things are stripped out. If you're worried someone is going to kill themselves, it's a natural response to take everything away. If someone stays in a room like that on their own for extended periods, it can be very damaging to their mental health.

51. Part of the problem was blame culture. People were trying to see what went wrong and who they could blame for that. In that kind of culture, people become very risk

averse. As a result, inmates were put into cells with canvas gowns and nothing around. It didn't matter that they were damaged later on and had problems in their lives, that had nothing to do with the Prison Service at that time. They managed the individuals during the period they were there and they got released alive.

52. The group didn't receive any evidence about abuse occurring in the mid-1980s. There was no suggestion of abuse in any of the Fatal Accident Inquiry determinations and I was involved in reviewing all seven. In one case, there was a suggestion about bullying from other inmates but no institutional abuse by staff. With the exception of one suicide, most of the deaths had been accidental or a cry for help which went wrong.

53. My own role in the group was a difficult one. I was supporting and facilitating the group, providing advice and experience about prison and assisting in the researching for and drafting of the report. There was also a difficult line to be walked between being a member of a group which might be critical of SPS and being a member of SPS. Some directors of SPS were very progressive and there were periods of wanting change and improvement. At other times, that was not the case. In the recommendations, there was a finding that the SPS needed to plan policy and not be reactive. That was a criticism of SPS management, who were my bosses.

54. The review started the process reflected in the later 'Act and Care' strategy of moving away from passive observation to interactive involvement. The second version of that strategy was called 'Act2Care', which became the suicide prevention strategy in the Prison Service. The Chiswick response was that we needed to be more engaged with prisoners and move from a passive viewing role. In those days, while inmates backgrounds were taken into account, like marital break-up, foster care or children's homes, truancy and exclusion, there was no articulation of trauma and what that did to people.

55. The recommendations of the Chiswick report included a change in language from strict observation to terms used in hospitals. We suggested that decisions about an inmate should not be taken by one person (individual culpability) whether that be a psychiatrist, a doctor or a member of staff. There should be more of a team approach

and a discussion. Act2Care resulted in prisoners themselves being more involved in decisions about their own management and how they were looked after. Prisoners were supposed to be managed in a more interactive and less draconian way. Changing culture in Glenochil and the organisation more generally happened gradually. Work was done on suicide prevention.

**Scottish Prison Service National Suicide Risk Management Group**

56. There was a vacancy on the SPS board in 2001. I rebranded a role for myself and became director of Rehabilitation and Care and was in that post from 2001 until 2006. It summed up what we were about, the education, training and rehabilitative functions together with the care aspect, including health, mental health, psychology and psychiatry. Whilst in that post, I chaired the National Suicide Risk Group. The group involved prison healthcare staff, including the head of healthcare, healthcare administration and the head of psychology, and individuals from the voluntary sector and organisations like the Samaritans and Families Outside.

57. We looked at and reviewed the Act2Care forms and reviewed how the systems were working. The healthcare people undertook audits of the forms where there had been a suicide attempt or suicide. We linked with organisations outside of prisons, such as the Scottish Government and their suicide prevention strategy. We also considered what was being done by HMPS in England and Wales. We worked with social work and the voluntary sector in relation to drug deaths from prisoners upon release. We transferred funds from SPS to the community for throughcare support on release. Often, people released from prison overdosed within the first few days.

**Abuse and extent of abuse in SPS institutions**

58. I was aware, and even more so nowadays, that abuse can occur in any setting and that it may not have simply existed 'elsewhere' but in one's own sphere of work or activity. To some extent, the opportunity for abuse is increased where there are

differences in power, such as between staff and inmates, or behind closed doors, such as in homes and institutions. Even though there exist checks, such as visiting committees in the past and now independent monitors, the inspectorate and systems of complaint, no such system is perfect or comprehensive. We also rely on people, actors in the system, such as staff, especially senior staff, to monitor what goes on to prevent abuse and maintain individual's rights and integrity.

*Sexual abuse*

59. With the exception of the chief officer at Glenochil, I am not aware of any sexual abuse being perpetrated by staff throughout my time at SPS. Although a prison is a closed community, it is a community and any wrongdoing does not go unnoticed. It may not be reported, but it will be known about. Inmates talk to each other and would hear what was going on in neighbouring cells. Staff also talk to each other. That doesn't prevent abuse, but it is likely that more than a perpetrator and victim would know. Sounds carry. There are also systems in place for safety and security to prevent irregularities, so that when inmates are locked up at night, or when most staff are off, cell keys are not available except from sealed packages held by patrol staff. In my time working in borstal, detention centre and young offenders institutions, I am not aware of any allegations of sexual abuse by staff.

*Physical abuse*

60. Physical assaults by staff happen, but are sometimes difficult to prove. It might have been the result of an argument between an inmate and an officer and things got out of hand, with either party being the first aggressor. It is also the case, anecdotally at least, that where a member of staff has been assaulted, particularly where this has been severe, that other staff might take physical reprisals. Sometimes the restraining of prisoners may have been more than the minimum force required.

61. Abusive practices by staff occur, but it is hoped that with good staff, good training, good supervision and support that such abuse is minimal. Abuse need not be physical, since custodial staff are responsible for the 24/7 management and wellbeing of their

charges. It is therefore possible for staff to discriminate against individuals so that, for example, they are at the end of a queue for food at mealtimes and thus get less choice, or are opened up later than other prisoners and have less time, and so on. Staff are involved with mail and correspondence, visits, searches, and if they chose to pick on someone, might place one prisoner on a misconduct report for something that they would not do so for another. Staff are also required to write reports and these can affect wages at work, a prisoner's chance of parole or progress within the prison system. These more subtle forms of abuse are less easy to detect but also rely upon others observing and moderating what might occur and whether people believe that complaining has any effect. In the end, prison is a closed society but, in the main, only functions if both the inmates and staff have a reasonable working relationship. Abuse can create problems for the running of organisations and in some cases lead to disruption by inmates.

62. Unlike schools where the tawse and corporal punishment were only banned in 1987, physical punishments in Scottish prisons were abolished in 1940, apart from cases of mutiny and severe violence to staff, and this came to an end in 1952. Corporal punishment has therefore not been used in Scottish prisons for seventy years. It therefore continued in Scottish schools long after its use ceased in prisons.

*Peer abuse*

63. Violence, bullying and intimidation between prisoners can and does occur. It is for those in authority, staff and management, to create the environment where this is not acceptable. This is not easily achieved and the prisoner sub-culture will mitigate against this and establish its own norms. In terms of sexual abuse between inmates, it is also hard to know what occurs. There has always been the possibility of sexual activity between inmates. Undoubtedly where this occurs it is also difficult to know whether it is consensual or abusive.

64. Anecdotally, there will have been alleged cases of rape. If these were reported to staff then they would be further reported to the police for criminal investigation. However, we also know that even among the general public reporting of such incidents is low.

Additionally, both victim and perpetrator live in the same institution and the same power structures and culture remain after the incident. Even if the individual reports the abuse and is relocated to another institution, word can travel making their life very difficult.

65. Prison staff contribute information to intelligence systems so it is possible to build up information on individuals. To do so, prisoners must talk to staff and staff must remain vigilant.

*Reporting of abuse*

66. I don't think the term safeguarding was part of SPS policy in the 1980s. I don't think those concepts were really thought about. There were things about rights, fairness, complaints and how we looked after people, but we hadn't at that stage thought about safeguarding. We just don't know the prevalence of abuse, which is both difficult to prove and define. In terms of inmate-on-inmate abuse, there may be a reluctance to tell someone for fear of being labelled a 'grass'. Some statistics exist on assaults and fights between inmates and assaults on staff, which SPS can provide to the Inquiry. There is less information on abuse by staff.

67. When complaints were made against staff, these were investigated, but staff may close ranks and then it is harder to get evidence. As a governor, I had to deal with prisoners for a misconduct report in the quasi-judicial setting of an 'orderly room'. I would hear evidence from both parties and witnesses and arriving at a decision, most often a finding of guilt followed by a punitive sanction. I also had to deal with staff under the Discipline Code, where a finding of guilt led to a recommendation for dismissal. I recall at least one case where staff evidence seemed contrary to what may actually have happened and, in my view, frustrated a just outcome. However, the system also depends upon both parties accepting the authority of the prison.

68. It is also open to both staff and prisoners to make a complaint to the police for criminal investigation. The governor could decide that a matter should be referred to the police for investigation, but that didn't happen very often. Normally, that happened in cases

where a prisoner was alleged to have assaulted a member of staff. If a prisoner assaulted a member of staff, both parties were often happy for it to be dealt with internally. For the prisoner, there was less chance of the matter affecting them and resulting in a further conviction or their sentence being extended. For officers, if the circumstances were a bit questionable and they shouldn't have been in the position that led to the argument or to things getting out of hand, they might have been more happy for it to be investigated locally than by the police.

69. One suspects, in the absence of strong corroborative evidence, that the police are unlikely to take the word of a prisoner – a convicted criminal – against that of a prison officer. There is simply an imbalance of power in the system. Prisoners also have complaints processes within the prison system, but usage may in part depend on how fair and impartial they perceive them to be. When prisoners complain, their complaint is normally dealt with locally. Unfortunately, the internal complaints system is a bit open. Staff can normally see and will be asked to respond to a complaint in the first instance. If a prisoner complains, staff will see that complaint early on which can be a disincentive. They can also complain to the visiting committee, but I'm not sure how that access works nowadays. Inspectors may invite people to talk about certain topics, but that depends how the inspection is carried out. It's difficult for people to open up about difficult subjects unless they feel comfortable doing so. Some prisoners may choose to contact a lawyer, which they have a right to do. I think prisoners were aware that it was open to them to complain to the governor, although they may not have been aware of all the avenues of complaint.

70. There was something about complaints, rights and access to lawyers in rules issued to inmates when they arrived in prisons and young offenders institutions. I have provided a copy of 'Abstract of Rules and Regulations for Detention Centre Inmates' to the Inquiry which dates from 1976. Paragraph 21 refers to complaints or requests. A copy of these rules would have be placed in every cell. The problem was not so much the reporting of abuse but the learning of abuse taking place. If the knowledge doesn't come to you as governor then there's nothing you can do about it. I certainly would have dealt with any incidents that I heard about. If governors turn a blind eye to young people being punched, assaulted or given a hard time then abuse will take

place. If governors look underneath and try to make sure that things are running as they should be then things will be better. You need to have good leaders. You can't simply rely on good people from the bottom up. People need to understand the values of the organisation and follow through with procedures, policies and rules.

*The impact of abuse*

71. It is difficult to measure the impact of abuse as different types of abuse will have different impacts. The impact depends on a whole range of factors, the individual and their own robustness and ability to cope, the context, and any supports to aid resilience. In general, abuse can lead to trauma. The impact of trauma can lead to the acting out of behaviours and moods, and in some cases can lead to self-harm or even suicide. The acting out of behaviours in any setting can cause consequences for the individual. In school, it might lead to trouble, truancy or exclusion. In a custodial setting it can create a downward spiral of behaviours which cause problems to others or cause the individual to get into trouble, losing freedoms and privileges, wages, association with others and being more isolated.

72. There are other forms that 'abuse' might take. Particularly for younger people, increased obstacles to family contact could be seen as being impactful or as a consequence of acting out behaviours. We do not know the long-term impact of how we dealt with young offenders during disturbances in institutions in the 1980s. In addition to my role as a governor, I was involved in the management of riots and hostage taking incidents around that time. The first major incident was at Edinburgh Prison in 1987. I was asked to do a review of that incident. There were then two subsequent incidents in Peterhead and Barlinnie and my role continued. I produced recommendations which set up the incident command team structure. We got 'tooled up' to deal with incidents which became quite antagonistic towards staff. That went on for a number of years and inmates and staff were certainly traumatised throughout that time.

73. When I was deputy governor at Glenochil, riots took place in 1986 and 1988. Dealing with misconduct reports, I sat in a quasi-judicial function. People weren't denying that

they wrecked the place and ripped it apart. I don't know whether staff had been injured. Of course, as the deputy governor I was going to say that this was wrong. Those guilty were locked up and lost remission. Some young offenders would therefore be in cells for quite a long time, especially if they carried on being angry and acting up. It was a very difficult position for both sides to be in.

74. When I moved to my post at Edinburgh Prison in 1996, there was a section of the prison allocated for young offender remands. When I went round the prison, I discovered that virtually all of those cells did not contain proper furniture, such as a cupboard to store clothes and property. They often didn't have proper cutlery and had plastic cutlery with the handle broken off. This was because some time before, many months or years before, the furniture had been destroyed in disturbances. They were not replaced, at least at the time, because it was felt that young offenders might smash them up again. But as they had not been replaced, subsequent young offenders on remand were being made to suffer for something they were not responsible for, that had happened a considerable time beforehand.

75. We were the biggest hotel in Edinburgh. I asked one of my senior managers to go out to hotels and see how they managed to get clean rooms with, bedding, soap and whatever else. We had workshops in the prison and all this broken furniture. I told them to get it repaired in the workshops and start making the place look good. I said I didn't care how much it cost, I wanted the whole prison repainted and every cell properly equipped. We overspent a bit and I had an argument with the SPS director at the time. I told him that if things were needed, there should be no argument. Otherwise, when we were criticised in the next inspection report I would say that I couldn't improve things because he wouldn't give me the money. It's about care and it's about standards and treating people with dignity. I wanted to get offenders involved in programmes and education, but if they don't have their own self-respect why should they want to do other things? If you treat people like animals and not humans in their day to day lives they won't want to do other things. You need to start with the basics.

76. Continued housing in poor conditions after accommodation was destroyed and, for some, extended periods in segregation must have left emotional scars. These

disturbances may also have had an impact on staff, who work in these settings and are also affected by disturbances and rioting or hostage taking and can be subjected to trauma as a consequence. There was no additional support for people who had witnessed rioting. Staff who had been directly involved in hostage taking were given some additional support. In the main, we all had to get on with it and turn up the next day.

77. As a consequence of the rioting, SPS realised the need for better prisoner rights. There was an increased recognition that prisoners should be treated as individual citizens with rights who had to be incarcerated rather than people who were being sent to prison to lose all their rights. That was a sea change over that period and led to the publication of a document called 'Opportunity and Responsibility' in 1990. It signalled the sea change in terms of how we dealt with and case managed longer term prisoners on an individual basis. We treated prisoners as citizens inside in the hope that they would carry on as citizens when they were released. It also coincided with changes to human rights and a greater understanding of complaints procedures.

*The use of restraint and segregation*

78. Governors have the power to order segregation and at times restraint. Restraint, which would normally imply the use of some mechanical body restraint or manacle, is usually only applied following consultation with a medical practitioner. It would be undertaken for an individual who is perceived to be unwell, often lashing out, and a danger to themselves. This is only applied in exceptionally rare circumstances, carefully circumscribed and for limited duration. The inmate would be located in a segregation cell or a special 'silent' or 'strong' cell. When it is applied there should be frequent observation and interaction with staff. I can only recall it happening on two or three occasions in the course of my career and it probably only happens once every two or three years in a prison establishment. As far as I'm aware, this was properly recorded when used. A medical professional would be involved and it would be reported to headquarters.

79. Governors should be mindful of the wider implications of such restraints and review, that such actions might come under the purview of European Committee for the Prevention of Torture and Inhumane or Degrading Treatment or Punishment, as indeed might any use of 'silent' or 'strong' cells. The use of isolation is a problematic concept, since even ordinary prisoners are locked up in their cells in isolation overnight. Isolation in segregation is more severe as it can be associated with sensory deprivation.

80. Also, unhelpfully, the term 'restraint' not only means the type of restraint described above but can also be used to mean the restraining of an individual in the sense of, for example, a member of staff holding a prisoner, or taking him by the arm from one place to another. There are prescribed procedures for control and restraint of prisoners and movement of prisoners under these conditions is undertaken by a team of staff and recorded. It can be a way staff of controlling individuals if a fight breaks out. They are trained to use appropriate responses. It does involve the infliction of pain and the more people struggle, the more painful it is. It has to be a legal use of force which is why it is recorded. Any of these systems are open to abuse. Staff can always apply a bit more force than is necessary. For that reason, it is normally carried out by a team and there is a senior member of staff who monitors that it is being done appropriately.

81. Segregation is part of the armoury of management of prisoners, though usually only applied as a last resort or due to the severity or immediacy of the situation. Although segregation is used as a punishment, in recent times improvements have been made to the living conditions in segregation units and thought given about how to re-introduce the prisoner to normal prison life at an early juncture. Segregation can be used for a number of purposes: to punish an individual; to remove a prisoner who is causing a problem to others from normal prison life and routines; to remove a prisoner from others for his own good where it is feared he may be in danger; and to be able to better monitor a prisoner in more secure or safe surroundings and where they may be a danger to themselves. It's quite a broad spectrum.

82. Where segregation is not a consequence of a punishment the governor must apply under the Prison Rules to keep a prisoner separate from others. There are procedures

for checking the health and wellbeing of the individual. Segregation can, to some extent, also be achieved by locating a prisoner in their own cell, out of association with others.

83. Segregation usually implies a fairly sterile and ordered regime. The cells will have little in them, as a spartan environment, to prevent objects being used as weapons or for self-harm. The clothing may also be different. The window is likely to be small and constructed in a way that it cannot be used for self-harm, as are the light fittings and, if included, any sanitary fixtures. Routines may be limited to washing, cleaning and ablutions, meals, and to exercise. Additional interaction with officers, medical or therapeutic, may be built into the regime.

84. It's the duty of the governor or one of his representatives to visit all parts of the prison every day. There is the potential to see those in segregation individually. I would do that and check that those in segregation were alright. The experience is undoubtedly negative. When used to excess, as for example it was during the 1980s when disturbances, destruction and arson, rioting and hostage-taking took place, individuals became more hostile, alienated and suffered longer-term problems. For the most dangerous cases, staff might wear protective clothing which exacerbates difficulties in fostering relationships. Segregation will be seen as coercive and there is always the potential for violence. If people are locked up, you don't know what their mood will be when you open the door. There is always the potential that things might go wrong. This may thus involve physical restraint by staff, taking hold and control of prisoners in prescribed ways. If a prison officer is feeling angry and a prisoner has just assaulted one of their colleagues, are they going to use the least force to get the prisoner back into their cell? Who knows how they might respond. Although there are cameras in prisons nowadays, they may cover one area every ten seconds so there is a nine second gap between footage. There were certainly occasions when I was left unsure about what had occurred.

85. Prevention of suicide is a difficult problem per se. It is not easy to interpret signs even when there are close relationships, such as within a family. Things are made harder

in secure settings by perhaps a lack of friendships and isolation. Those responsible for care are not always able or sufficiently resourced to monitor changes closely.

86. Prevention of suicide is not a physical act, unless in the exceptional circumstances of seeing someone in the process of doing so. In the past, whilst the physical aspects such as the use of canvas clothing, or cells which had no points on which a ligature could be hooked proved to be reasonably successful at preventing suicide, the process of isolation and being observed over periods of time caused emotional and mental distress.

87. What is required is engagement and interaction, good communications and relationships. Staff should be able to see signs, listen to others and encourage awareness among the inmate group. Showing a balanced response to risk and not overreacting is important, as overreacting by staff can cause a reluctance to report or express concern. Risk aversion and blame culture can sometimes lead to counter-productive responses to signs of distress. Team and interactive approaches to risk should be used. In the past, if an inmate said they felt suicidal they would be put into segregation cell with a canvas gown. There was nothing in the cell except for cardboard furniture and a bible. The alternative is not to tell anybody and feel suicidal. What you want is for someone to say that they're feeling depressed or suicidal and then be able to talk it through with them and monitor them daily. Prisoners can now access the Samaritans. There are buddy schemes in some prisons and personal officers schemes, where a particular member of staff is meant to be more aware of an individual's needs. I think the personal officer scheme was brought about in 1990 when we tried to improve things for long-term prisoners. That was extended to short-term prisoners in the early 2000s.

**Staff recruitment, training, culture, performance and suitability**

88. SPS does concern itself with staff recruitment. It tries to recruit appropriate staff and sift out those who would not be suitable. I was not involved in the recruitment of basic staff, but I have been involved in recruitment to governor and managerial grades and

promotions. Part of our assessment included the candidates attitudes and values and respect for others. Training also included the rights of prisoners, how to treat those in our charge and, for example, requests and complaints procedures and disciplinary matters.

89. Culture, in part, is set by those in charge so that how you treat individuals, respect and rights can be modelled by senior staff as they go round the prison. And not walking past anything that does not appear right. To notice something and not do something about it, in my view, signals to others that it is acceptable. I have attempted to change the culture within penal establishments in many of the places I have worked and it is not an easy process. From wearing name badges and accountability to staff not wearing protective body armour, or from working with sex offenders to respecting and valuing female staff in an institution for males, cultural change can be difficult and requires strong leadership and buy-in from staff.

90. Performance is also something SPS takes seriously and staff appraisal is an important feature of their management. A good appraisal system helps with achieving the objectives and performance of an organisation. Those who undertake it require training and also the strength and confidence to be honest with those who they are appraising. It should also help identity those not performing well or indications that behaviour is not as it should be.

91. In the end, culture and what goes on in institutions is a product of joint enterprise. Leaders must model appropriate behaviours and values and staff have to want to emulate them. Leaders must also be attuned to what is going on and pick up when what they want to achieve is not happening. Staff, if properly motivated and supported, should also be aware of what is happening and influence others to change.

92. I am not aware of the current procedures of vetting deployed by SPS. I would presume that all staff are checked by 'Disclosure Scotland' and reviewed on a regular basis. The Glenochil report led by Derek Chiswick was critical that there was not specialised training for staff working with young offenders. Staff tended to be posted where there was need rather than in areas they may have been suitable for. Earlier on, recruits

who had been in the army were often posted to detention centres. I think recruits might have been asked if they wanted to work in specific places, but there was very little by way of training other than the prison rules. There was very little, if any discussion about the needs of youngsters and their vulnerabilities when I was at Glenochil. By the end of my operational career in 2001, the training process was starting to distinguish between different prisoners and awareness the vulnerabilities of young prisoners was increasing.

**Inspection, management and oversight of establishments**

93. Inspection systems do not always uncover when things are going wrong. Much depends on the awareness and openness of those inspecting to sensitivities and sometimes to what is not said. Inspectors need to be able to pry a bit. People might say what they think you want to hear. Inspectors need to have the ability to talk privately and in confidence with prisoners, and to recognise the differences in the nature of complaints and the systems that are meant to be in place for things to work properly. Inspectorates have to be open and sensitive. Visiting committees have been largely abolished. I think they were probably better than what came as a consequence of changing them. They may not have been prefect, but it may have been better to change something that was imperfect rather than replace them altogether. I can't really comment because visiting committees were still in use when I was at working for SPS.

94. Inspectorates are organised systems that go into a prison. It's human nature that they might go in with ideas of things that they want to look for. They might be looking at that aspect rather than looking for other things. It's difficult to go in with a completely open mind and absorb everything. They normally go in with a focus of things they might have seen in a previous report. They may have a few things that they particularly want to look at, which is understandable when you have a big institution. They can only do so much, even in a week. Inspectorates will state that they don't deal with individual complaints, rather they are looking into systems and processes. However, sometimes you can only judge systems processes by how individual things have been dealt with.

Maybe they do need to track how individual complaints have gone through the system. I don't know whether they do that.

95. There needs to be proper unimpeded access to complain. Management and governors have a clear duty to ensure all complaints procedures and systems are in place and that the statutory rules and prison circular instructions are followed. A number of these are designed to protect inmates and afford them rights and avenues of complaint and redress. Prisoners need to be aware of the complaints procedure and feel confident in them. It may also depend on what the prisoners is complaining about as they may find it difficult to complain about a member of staff.

96. In 1997 I had the unenviable task of investigating a governor-in-charge of a prison establishment for adult men. His style of working, in relation to his staff, led to him being investigated under the Discipline Code for 'oppressive and tyrannical behaviour' and also for corruption. I took evidence from all staff. It was clear that his way of working had caused distress to quite a few staff. They were also worried about their part in some of his less than proper activities. If there are corrupt activities going on and you are asked by the governor to participate, it is difficult for staff to know what they should and shouldn't do. So it is important that those in charge, our leaders, model acceptable and appropriate behaviours.

97. In the course of my investigation, I did find substantial evidence that the governor had operated in a tyrannical and oppressive way. As a result, the chief executive of SPS accepted the resignation of the governor concerned which meant he avoided going to a formal disciplinary hearing. It wasn't for me to decide whether the governors conduct had been criminal. My report also contained various recommendations about how the next governor should deal with the institution and what sort of psychological and other support should be available for staff. It identified various policies that should have been improved and changed so there was no repetition of what had happened. It was also critical of board members.

98. In the course of my report, I felt I needed to write a page about the role of governor and the standards that should be upheld:

*"The governor of a prison is someone who is appointed to be the head of that establishment. It presents a unique management role and carries with it awesome burdens of responsibility. Not only is a governor the 'chief executive' of his or her prison and accountable for its staff and the management of its resources but, on behalf of the Secretary of State, he or she hold persons in custody and exercises disciplinary and delegated powers which can affect the conditions in which they are held and their release dates. The Prison Service is also a discipline service, run in an hierarchical way, so that its staff are also subject to discipline and control in the exercise of their duties. The governor is, therefore, at the pinnacle of the organisation and is expected to exercise his or her powers in a fair and just way. For many purposes, the governor is the final arbiter of what happens within his or her establishment, and it might take a strong individual to challenge the exercise of those powers if, in so doing, that individual were to offend the sensibilities of the governor. If, for example, a prisoner or member of staff were to value being located in a specific prison, then the fear of being transferred as a consequence of complaining might mitigate against complaining or challenging decisions. Governors must therefore demonstrate scrupulous fairness and ensure that those within their establishments feel free to exercise the ordinary avenues of complaint without fear of recrimination.*

*The governor must also model by example high standards of propriety. As a civil servant he or she must not be seen to gain personal advantage from the circumstance of his work, and the governor is expected to have a feel for that which is correct and avoid any involvement in matters which could lend suggestion that the individual is abusing his or her position for personal gain. While such circumstances are sometimes hard to prescribe in advance, they would certainly come under the category of 'I know one when I see one' and should be self-evident as inappropriate action or benefit. A governor should conduct his or her affairs in such a way as to avoid suggestions of impropriety in the exercise of powers over staff and prisoners and in the use of resources. In everything that is done he or she should strive to be always above reproach.*

*The above are not merely fine words, ideals to be taken out of the cupboard from time to time when required, polished up after they've become tarnished, and returned to*

*storage after use. These standards apply to governors-in-charge and all senior staff, be they other governors, headquarters personnel or members of the Prisons Board. It is our duty to ensure that we both model and monitor these values. When we observe a colleague who falters it does none of us any credit to overlook or excuse what occurs. The result is all too obvious from the chapters which follow."*

**Child protection and safeguarding arrangements to protect children and young people from abuse**

99. In my time in SPS, I worked in prison establishments holding young people. I have to admit to not having particular awareness of any child protection and safeguarding arrangements or indeed issues. In the prison system, 'a child' was defined as a person under 16 years of age so that, in principle, SPS did not hold any children. It was possible that a child under sixteen could be held in prison on an 'Unruly Certificate'. This would be the result of a child appearing before a criminal court and being remanded in prison by a sheriff due to their 'unruly' character or behaviour. This was abolished in 2010. In the first decade of this century numbers gradually decreased from 35 down to 5. However, it is still possible for a child between the age of 12 and 16 to be sentenced to detention for indictable offences.

100. I do recall children being held in Edinburgh Prison on unruly certificates when I was governor there. Normally it was until a social worker could find them suitable secure placement elsewhere. Prisons have responded in a variety of ways when required to house children. Children have been kept apart, often housed in the prison hospital area. This encompasses the notion of protection for vulnerable children in a broad sense, from both physical abuse and being in a criminal environment. For a number of years, no children under 16 have been located in penal establishments.

101. However, prisons still hold young offenders, but whereas five years ago the numbers of 16 and 17 year olds was around 50, and 18 to 20 years olds around 350, that number had gradually reduced to around 5 in the 16 to 17 year old group, mostly on remand, and 150 18 to 20 year olds. There is even a stronger case for abolishing

imprisonment for those under 18 years of age now that the numbers are so low. There has been enormous pressure on the prison system, by social work and the Sentencing Council to reduce the numbers of children and young people in prison. There has been a decrease, which is a good thing.

**The response to reporting and complaints of abuse of children and young persons**

102. Complaints of staff using physical violence would be dealt with by investigation, usually by the police, and may also lead to investigation under the discipline code for staff and subsequent disciplinary action. I am not aware of any complaints of sexual abuse of children and young people during my time at SPS. If there were to be a report or complaint of a specific offence about a member of staff then I feel certain that appropriate action would have been and would be taken to progress the matter. Of course, in a penal institution, both the potential victim and perpetrator live and work in the same setting. There could be pressure, unknown to others, to keep quiet about any abuse perpetrated. Without an individual victim telling someone else it would be difficult to know. If this occurred and another inmate discovered it then it would be hoped that the complaint or abuse would come to light.

103. There are possibly cases where the abuse takes the form of verbal abuse, bullying, intimidation or causing mental distress. This is more likely to be spotted by others since the person perpetrating the abuse may do so in the presence of others, perhaps to humiliate the individual. When such cases are discovered the matter is dealt with appropriately, depending on whether the perpetrator is an inmate or a member of staff and the resources available, including investigation and disciplinary outcome, training and relocation. There are anti-bullying and whistle-blowing policies which allow individuals to report abuses. These are in addition to the general management and supervision of staff and the various procedures for complaining and reporting of inappropriate staff actions. People need to feel that they can report abuse and be listened to.

**Lessons to be learned**

104. The first golden rule would be that under 18s should not be in custodial establishments. More generally, this should apply to under 21s but it will be hard to move the system. If we change the system and place children and young people in secure units, we may have reduced the prison numbers but we may just have moved the problem. Some young people may feel better in a place that is actually for adults rather than a secure local authority setting. Prison might fit better with their self-defined labels/identity. The best solution is to keep people out of prison. Prisons are okay for the three thousand or so people in Scotland who have committed more serious offences and need to be there for public safety. Around 50% of prisoners don't need to be there for the safety of the public.

105. I think that we should move to community courts. The Procurator Fiscal needs to be more enlightened. If people are reported to the Procurator Fiscal by the police, a decision should be made as to whether it warrants a prison sentence if they were to be convicted. If the Procurator Fiscal decides that it's not sufficiently serious, they could go to a community court that can't impose a prison sentence but can impose unpaid work or training on a needs based system. In 1967 the Kilbrandon Report resulted in the introduction of a Children's Hearing system that was said to be needs based. The criminal justice system remained deeds based. It was either one or the other. The Children's Hearing system attempted to offer support and help people out of their problems, recognising educational difficulties, trauma or difficult upbringings. We flipped the coin with adults and said it was all to do with the offence. Very little cognisance was taken of family circumstances or anything else.

106. Some sheriffs are very liberal and try to keep people out of prison. Other sheriffs are known to build up the prison population. There are two polarised views. I know that the Sentencing Council has started to suggest that other factors are taken into account, but my vision of the community court is that both needs and deeds would be taken into account. The problems could be looked at in context which would identify the appropriate way forward that lessens the chance of reoffending and somehow repairs the damage to the community.

107. It should be ensured that the child or young person has a voice and is listened to. That can be difficult in penal establishments. There should be an opportunity for some independent safe-guarder to privately talk to the young person and to keep in touch with them. There are already advocacy workers and buddying systems. Maybe they need to be enlarged and expanded upon. It should also be ensured that the child or young person has access to appropriate family members to provide support and someone to talk to and share any concerns.

108. When a young person is incarcerated, he or she should be housed in a dedicated unit, free from adult remand or convicted offenders. The staff, including management, should be carefully chosen, from those who are motivated to work with young people, appropriately vetted, and given additional training for working with this age group, understanding their needs, vulnerabilities and the possible traumas they have already been subjected to. It should also be ensured that proper safeguarding measures are in place.

**Helping the Inquiry**

109. Goffman's work *Total Institution* is still the go-to book for criminologists looking at institutions. Scandinavian prisons are much smaller and closer to the homes of prisoners. In the early 2000s, one the first debates I lost at SPS headquarters was about the prison estate. They were talking about economies of scale and bigger prisons. I was arguing for smaller prisons. Prisons had gone from housing about 250, 300 to about 750 prisoners in Scotland whereas they held about fifty prisoners in Scandinavia. Maybe smaller places could be more open to abuse taking place, but on the other hand staff get to know people better and lots of positives can occur. Smaller prisons are far less impersonal. The UK government was talking about a super-max prison at one stage, housing 3000 prisoners. Barlinnie used to be able to hold up to about 1500 prisoners. It does then become a machine and it becomes less personal. Institutional abuse can take over as well.

110. Most criminologists and people working within the prison service believe that most victims of crime want to know why they were a victim. They want the victimisation to stop and to be recompensed for what went wrong. It's about knowledge and restoration. They're not as interested as politicians seem to be in locking up the perpetrator and throwing away the key. Sometimes it's about restorative justice processes, talking about why somebody did something. There is a tabloid perception that we need to get tough on crime, but a lot of the surveys seems to show that the public are not as punitive. They'd like to see reduced crime and they'd like to see a sensible, balanced arrangement but not an extension of the punitive nature of the system. We have an adversarial system in our politics and judicial system which is probably why we have a high level of imprisonment in comparison to other European countries, even though rates of crime are similar.

111. In providing my evidence to the Inquiry, I've been asked questions about what can be done in institutions to protect children and young people from abuse. The Inquiry should not overlook the benefits to child protection from having a prevention strategy or perspective, trying to find potential or actual perpetrators and helping them out of offending as well as providing information to help people understand how to improve protection. During my career, I was involved in sex offender programmes. I would commend the work of the Lucy Faithful Foundation in general and the Stop It Now Scotland campaign in particular. Stop It Now Scotland recently ran a successful joint campaign with Police Scotland, "Get help or get caught." They receive referrals from the police and run a confidential helpline. Work was also undertaken in prison by Stop It Now Scotland under the Survivor Scotland umbrella to assist people who suffered sexual abuse in order to reduce the risk of suicide. Stop It Now Scotland also works with persons who self-identify as actual or potential sexual offenders against children and their experience would be useful. It might be possible that they could also work with prison staff, in a general preventative and protective way.

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

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

Dated..... 9.1.2023