1 Monday, 18 March 2024

2 (10.00 am)

3 LADY SMITH: Good morning, and welcome back to Chapter 4 of
4 Phase 8 of our case study hearings, in which we are
5 looking into the abuse of children in residential
6 accommodation for young offenders and for children and
7 young people in need of care and protection.

8 We move to another section this morning, and no
9 doubt Mr Peoples is in a position to explain briefly
10 where we are going next.

11 MR PEOPLES: Yes, my Lady.

12 This chapter is concerned with two institutions,
13 both run by Local Authorities, Larchgrove and Kerelaw.
14 Over the next three weeks we will hear some evidence
15 about both from a variety of sources, including
16 applicant evidence, both orally and read-in, and also
17 evidence from other parties.

18 Today, our first witness will be a person who is
19 representing Glasgow City Council who has given evidence
20 before, Susanne Millar.

21 LADY SMITH: Yes, thank you.

22 Susanne Millar (sworn)

23 LADY SMITH: Good morning, Susanne, and welcome back.

24 Do sit down and make yourself comfortable.

25 Susanne, you know how it works here. We haven't

1 changed the system of how we run our evidential sessions
2 and you will find documents that relate to your evidence
3 in the red folder there.
4 Let me remind you, if you need a break please tell
5 me, and I know you could have a long day ahead, we will
6 see. Or if there is anything that you want to ask
7 about, speak up, don't sit there staying silent and
8 feeling that you can't take the initiative.
9 If you are ready, I will hand over to Mr Peoples, is
10 that all right?
11 A. Yes, thank you, my Lady.
12 LADY SMITH: Thank you.
13 Questions by Mr Peoples
14 MR PEOPLES: Good morning.
15 A. Morning.
16 Q. Do you mind if I call you Susanne?
17 A. Of course not. Yes, please.
18 Q. Susanne, today, as just has been said before you came
19 in, we are starting a chapter of evidence in this case
20 study about two institutions, Larchgrove and Kerelaw,
21 both of which were run by a Local Authority. You appear
22 today, if I could put it broadly, on behalf of Glasgow
23 City Council and the Glasgow City Health and Social Care
24 Partnership?
25 A. Yes.

1 Q. What I can just say, by way of brief introduction, is
2 that you have already given evidence in our foster care
3 case study on, I think, Day 281, which was 11 May 2022,
4 and again on Day 342, which was 11 November 2022. At
5 that time you did tell us a bit about your professional
6 background, and I don't wish to repeat all of that, but
7 perhaps I can just briefly summarise the position and
8 you can tell me if there have been any changes since
9 then that we should know about.
10 First of all, at that point you were the Chief
11 Officer with Glasgow City Health and Social Care
12 Partnership, is that correct?
13 A. Yes, that's right.
14 Q. Are you still --
15 A. Yes, I am.
16 Q. -- the Chief Officer?
17 A. Yes.
18 Q. If I call it the Partnership --
19 A. Yes.
20 Q. -- just for short, you will appreciate what I am
21 referring to in due course.
22 I think you told us then that you started as
23 a social worker with Strathclyde Regional Council in
24 1992?
25 A. Yes, I did, yes.

1 Q. And you worked in the area of children and families
2 between about 1992 and 2001, with a generic caseload,
3 including children in foster placements?
4 A. Yes I did.
5 Q. In 2001 you moved into the area of strategic planning?
6 A. Yes.
7 Q. In 2006 you were appointed Head of Children and Families
8 within Glasgow City Council?
9 A. Yes I was.
10 Q. I think you told us, although we are not directly
11 concerned, that you subsequently assumed other areas of
12 responsibility, including homelessness, and asylum
13 seekers?
14 A. Yes.
15 Q. In 2012 you became Assistant Director of Social Work,
16 and you were also appointed Deputy Chief Social Work
17 Officer?
18 A. Yes, that's correct.
19 Q. In 2015 you moved to the Glasgow City Health and Social
20 Care Partnership?
21 A. Yes.
22 Q. That is effectively a partnership between Glasgow City
23 Council and Greater Glasgow and Clyde Health Board to
24 provide integrated health and social care services?
25 A. Yes, that's right.

1 Q. I think both bodies, the Council and the board, agreed
2 to delegate all health and social work services to the
3 Partnership, including children and family social work
4 services?
5 A. Yes, that's right.
6 Q. Initially within the Partnership you were the Chief
7 Officer for Strategy, Planning and Commissioning, and
8 you were also appointed, I think in 2015, as Chief
9 Social Work Officer?
10 A. Yes I was.
11 Q. In 2017 you became Chief Officer for Strategy and
12 Operations and from May 2019 you became Chief Officer of
13 the Partnership, in other words the responsible officer
14 for all of the services delegated to the Partnership?
15 A. Yes, that's right.
16 Q. I think you told us on an earlier occasion that Glasgow
17 City decided to have a separate Chief Social Work
18 Officer, and that individual sits within the
19 Partnership?
20 A. Yes.
21 Q. And indeed reports directly to you?
22 A. Yes.
23 Q. In turn, you as Chief Officer are accountable to the
24 Chief Executive of Glasgow City Council and the Chief
25 Executive of Greater Glasgow and Clyde Health Board?

1 A. Yes.
2 Q. So do I have all of that right?
3 A. Yes, you have, yes.
4 Q. You also told us that as far as this Inquiry is
5 concerned, you have been personally involved in
6 responding to requests by the Inquiry for information
7 and assistance since it was set up, and that you indeed
8 chaired and I think currently chair, is it --
9 A. Yes I do.
10 Q. -- a group that's responsible for all submissions to
11 this Inquiry?
12 A. Yes.
13 Q. And other members include the Chief Social Work Officer?
14 A. Mm-hm.
15 Q. And Dr Irene O'Brien -- who is a familiar name to us --
16 who is the Chief Archivist in Glasgow, is that right?
17 A. Yes, that's right.
18 Q. She is also a member.
19 I think you told us before that at different points
20 prior to today, the Head of Children's Services, or the
21 person with operational responsibility at a senior level
22 for children's services, has also been a member?
23 A. Yes, that's right.
24 Q. You also told us, I think, that within the group that
25 you chair there is also representation from the child

1 protection team, in particular an officer with
2 responsibility for investigation of historical abuse
3 investigations?
4 A. Yes, that's right.
5 Q. Where there has been requests that require historical
6 information to be supplied, I think you told us on the
7 last occasion, or at least one of the last occasions,
8 that the group relied heavily on Dr Irene O'Brien, the
9 city archivist?
10 A. Yes, that's right.
11 Q. For questions about practice and procedures, policies
12 protocols and so forth, responsibility I think for
13 coordinating responses within the group I think was
14 largely given to the Head of Service and the Chief
15 Social Work Officer, is that right?
16 A. Yes, that's right.
17 Q. What you told us is the way the group operated was to
18 meet collectively from time to time and agree a final
19 version of any response after discussion?
20 A. Yes, that's right.
21 Q. Then any finalised response is signed off by you as
22 Chief Officer with a recommendation to the Chief
23 Executive of Glasgow City Council for her signature and
24 sign off --
25 A. Yes.

1 Q. -- is that the way things --
2 A. Yes.
3 Q. I think you also told us that as Chief Officer you have
4 had discussions with recently retired senior Children
5 and Families workers who worked in social work in the
6 city over lengthy periods, some stretching back 40 years
7 or more?
8 A. Yes, that's right.
9 Q. The purpose of that was to gain some -- as I think you
10 put it to us before -- real life experience of what that
11 period was like to work as a social worker.
12 A. Yes.
13 Q. Although, I think you also have experience as a social
14 worker?
15 A. Yes, I have, yes, not quite 40 years, but -- yes, 36.
16 Q. My intention now is to move to Larchgrove first, and
17 then move on to Kerelaw, but before I do that, I don't
18 know if you can help us at this stage with what I might
19 call an overview.
20 My question is this: how has the involvement of the
21 Local Authority, and there has been a number of them in
22 the last 40 years, how has the involvement of the Local
23 Authority and the provision of residential care changed
24 or developed over that period? Are you able -- the
25 period from, particularly 1970 to date, because Kerelaw

1 was opened in 1970.
2 A. Yes.
3 Q. Can you give us some general overview about the main
4 changes, so far as you are concerned in terms of whether
5 it is legislation, whether it's policy, practice or
6 systematic changes in that period that stand out?
7 A. Mm-hm.
8 Yes, from my perspective I think the context in
9 which we are delivering services for children and young
10 people who require to be looked after by the state
11 I think has changed quite significantly in that time.
12 I think in particular when you look at some key pieces
13 of legislation based on children's rights, so
14 particularly the Children (Scotland) Act 1995 and its
15 update to making sure that children's rights and
16 children were at the heart of the work that we do in
17 social work services was one of the really more
18 significant shifts.
19 In terms of the specifics in relation to provision,
20 I think the biggest thing that's happened in my career
21 is a shift away from big residential to a real sense
22 that substitute family and fostering in particular would
23 be our first -- the first option that we would want to
24 pursue for young people who need to be looked after
25 outwith their families. And I think at points -- in

1 terms of the Inquiry's focus just now, I think at points
2 residential services were seen ... could have been seen
3 as the poor relation in terms of fostering. And I think
4 at the point where we were moving to substitute family,
5 as a profession we didn't give due regard to making sure
6 that the residential provision, which in my opinion we
7 will always require, was of the highest standard that it
8 could be.
9 I think there are -- in my experience, there are
10 children and young people for whom substitute family is
11 too problematic and too challenging for them, and who
12 are much more likely to be properly looked after in
13 a group living situation.
14 LADY SMITH: Susanne, as we heard in the foster care study,
15 foster care has its own challenges --
16 A. Yes.
17 LADY SMITH: -- whether you think in terms of finding foster
18 parents --
19 A. Yes.
20 LADY SMITH: -- or in terms of supervising properly --
21 A. Yes.
22 LADY SMITH: -- what is going on in the home, because in one
23 way, the potential for a child being abused in a foster
24 home is far higher.
25 A. Yes, my Lady, and exactly that. And I think the

1 Inquiry's -- the case study on fostering I think was
2 a timely reminder of that for us, and you will be aware,
3 my Lady, that we made sure that we had senior staff
4 listening to witness evidence --
5 LADY SMITH: Yes.
6 A. -- and I think for us some of the reminder of some of
7 the safeguarding issues for children in substitute
8 family situations, and how much more challenging that
9 can be to make sure we are doing it right.
10 LADY SMITH: So you are telling me, drawing on your long
11 experience, that the short point is we cannot assume
12 that we ever will or should get to the stage that there
13 is no provision of residential care in, let's just call
14 them institutions for the moment, because that doesn't
15 necessarily mean something enormous, institutions of
16 some sort?
17 A. Yes, my Lady. In my experience there are young people
18 whose own experience of family has been so toxic that
19 actually they are not able to manage a substitute family
20 situation.
21 Equally, there are young people, particularly if
22 young people are coming in as adolescents, where we can
23 work really hard to maintain a relationship with birth
24 family, and the time spent in residential care can be
25 about a rehabilitation. And again, in my experience,

1 particularly for adolescents, that's where you are more
2 likely to achieve that, in a group living situation,
3 because substitute family can be, can feel really
4 difficult for birth families.
5 LADY SMITH: Yes.
6 A. There can be such a difference in terms of environment
7 and care that birth families find it difficult to do the
8 rehabilitation. But in a group living situation you
9 have a better chance of working with birth families, and
10 maintaining those contacts, even if it doesn't mean them
11 being able to take full-time care. And that's not
12 always the case, it can be successful in substitute
13 family and fostering, but it is, in my experience, more
14 likely to be successful in residential child care.
15 LADY SMITH: Thank you.
16 Mr Peoples.
17 MR PEOPLES: If I could go back to this question of the
18 development and change, I think, obviously, we know that
19 there was significant legislation in 1995, the Children
20 (Scotland) Act, and there was obviously before then in
21 the context of residential establishments new
22 regulations introduced in 1987 --
23 A. Yes.
24 Q. -- that applied across the board for residential
25 establishments to replace a number of existing

1 regulations that applied to particular settings.
2 A. Mm-hm.
3 Q. We also know that there was the UN Convention on the
4 Rights of the Child in 1989, so these were all
5 significant developments on the legislative and
6 regulatory front.
7 A. Mm-hm.
8 Q. You mentioned how, perhaps, there will always be a need
9 for residential care services in your view.
10 A. Mm-hm.
11 Q. But that historically, and I think we have had evidence
12 of this, and I think it is documented as well, that
13 a figure you might be familiar with, Fred Edwards,
14 a former Director of Social Work with Strathclyde
15 Regional Council, was not a great fan of residential
16 care in an era when perhaps it was seen as the last
17 resort and one to be sparingly used.
18 A. Mm-hm.
19 Q. But then we came to a time when I think Angus Skinner,
20 as Chief Social Work Adviser, prepared a report in 1992
21 in which he, I think, set matters straight by saying
22 that residential care provision is important because it
23 is simply one choice, and it may be the best choice, for
24 certain young people --
25 A. Yes.

1 Q. -- and therefore you mustn't relegate it to being the
2 last resort option.
3 A. Mm-hm.
4 Q. And I think that sort of set the tone for the 1990s --
5 A. Yes.
6 Q. -- that you have to look at it in a different way. Is
7 that still the way things are seen?
8 A. Yes, very much so. But I also think we have continued
9 on that journey, so the residential, we call them
10 children's houses in Glasgow City, we operate 19, but
11 they are always on the city boundary. And they look
12 after no more than eight young people at any one time
13 and we go between six and eight, because it is very much
14 dependent on the young people there, and making
15 decisions about how best we can look after, but it is
16 never more than eight. All of the children's houses
17 have been rebuilt since 2006 and the vast majority of
18 them are now part of housing development, and in actual
19 fact they are indistinguishable. So the vast majority
20 of them are ordinary houses where the facade looks
21 exactly the same as the houses in the rest of the
22 development, but they are bigger inside because they
23 look after eight young people.
24 So we have deliberately undertaken a modernisation
25 so that the children's houses look like other people's

1 houses, and the children and young people are brought up
2 in their own communities.
3 Q. In a sense this reflects probably a trend that started
4 in the 1960s, moving from the large institutions to what
5 were termed 'group homes', with a smaller number, with
6 houseparents, but this seems to be taking it further in
7 that direction towards something that is intended at
8 least to have the feel of a family home?
9 A. Yes.
10 Q. With smaller units, which I think is the norm these
11 days, is it, for residential units --
12 A. Yes.
13 Q. -- in Scotland, in Glasgow, and elsewhere?
14 A. Yes it is the norm, yes.
15 Q. So that's the moving trend?
16 A. Yes.
17 Q. Away from big to small?
18 A. Yes.
19 Q. I think that, has there also apart from being a move
20 from big to small in the context of residential care,
21 been a move from general to specialist provision in
22 terms of residential care that there are places which
23 cater for particular types of need, in particular, and
24 indeed they set out in their descriptions that they
25 cater for a particular type of young person with

1 a particular type of problem. Is that the way we are
2 now?
3 A. Yes, in our children's houses within the city we don't
4 have -- they are not specialist, but they do have
5 a staff group who are now registered and trained. Where
6 there is residential provision that's very specific in
7 terms of its specialism, around about children affected
8 by disability. And we have children for all sorts of
9 reasons in terms of medical advances, we have children
10 with really significant disability who are living
11 longer, and for some families they find it really
12 difficult if not impossible to look after them. So
13 there is a particular specialist provision around about
14 those children, and when those children have ... are
15 impacted by disability, and that coincides with
16 significant issues around about neglect, which sometimes
17 it does, those kind of challenges that those young
18 people face do require a specialist response.
19 Q. Can I just be clear, as far as secure care services are
20 concerned, Kerelaw did have a secure unit --
21 A. Mm-hm.
22 Q. -- and we will find out a little bit about that, but
23 that unit closed in 2006?
24 A. Mm-hm.
25 Q. Am I correct in thinking that Glasgow City Council is no

1 longer a provider of secure care services?
2 A. Yes, that's correct.
3 Q. In fact there is no Local Authority now that provides
4 secure care services following the closure of Edinburgh
5 Secure Services last year, is that right?
6 A. Yes, that's right.
7 Q. Kerelaw had been a List D School --
8 A. Mm-hm.
9 Q. -- until 1986?
10 A. Mm-hm.
11 Q. It opened in 1970, or thereabouts?
12 A. Yes.
13 Q. It became what was known, post 1986, as a residential
14 school?
15 A. Mm-hm.
16 Q. Am I right in thinking that that Glasgow no longer
17 operates residential schools like Kerelaw?
18 A. Yes, that's right.
19 Q. If a Glasgow young person required to go to a specialist
20 school does that mean that the authority must contract
21 with a provider to take that young person?
22 A. Yes. But there are much stronger working relationships
23 with our own education services within the city. It is
24 highly unusual for a young person not to be able -- for
25 their educational needs not to be met by Glasgow city.

1 We have a number of specialist provision within the city
2 again.
3 Q. Yes, when you say specialist provision, do you mean
4 specialist provision within mainstream schools or
5 specialist schools?
6 A. Both.
7 Q. You have both?
8 A. Glasgow City has both. Most of it is in mainstream, but
9 we have a couple of specialist units. They are not
10 residential units, but we have a couple of specialist
11 units, particularly around about --
12 Q. To provide educational provision?
13 A. Yes, particularly around about autism.
14 Q. Okay, are they primarily a school?
15 A. Yes, yes. There is no residential provision within --
16 Q. A special school --
17 A. Yes.
18 Q. -- but they are day schools?
19 A. Yes.
20 Q. If someone required residential provision with
21 particular needs, special needs, does it follow,
22 therefore, that you would have to look to some other
23 provider and do you do that in practice, at times?
24 A. At times we do, yes. Currently it is really, it is
25 about that cohort of young people impacted by

1 disability. So we have only contracted at this point of
2 time 24 specialist placements, and those are all for
3 young people affected by disability.
4 Q. With third party providers?
5 A. Yes.
6 Q. And are they all within the Glasgow boundaries?
7 A. No.
8 Q. So you might have to go, if it is a particular kind of
9 specialist provision --
10 A. Yes.
11 Q. -- is to a facility some distance away in some cases?
12 A. They tend to be quite close, the greater Glasgow area is
13 where most of them are concentrated in, and most of our
14 young people, in fact when I looked on Friday, I think
15 all of our young people were 16 or over that within
16 those placements.
17 Q. So even if they are not within the city Local Authority
18 area --
19 A. Yes.
20 Q. -- these specialist residential facilities are generally
21 located within the Greater Glasgow area?
22 A. Yes, yes.
23 Q. And they are used from time to time?
24 A. Yes.
25 Q. If needed?

1 A. Yes.
2 Q. But the bulk of the residential provision these days are
3 children's houses?
4 A. Yes.
5 Q. Within the Glasgow City Council area?
6 A. Yes.
7 Q. And I think you said there are 19?
8 A. 19 of them.
9 Q. They house a maximum of 8 young people or between 6 to
10 8?
11 A. Yes.
12 Q. You have told us that there has been a rebuilding
13 programme in relation to these houses since 2006. You
14 did say, though, that they are not specialist in the
15 sense of they are not the specialist facilities with ...
16 I think you said people are trained to deal with the
17 needs of the young people there --
18 A. Yes.
19 Q. -- but they are not a specialist house for a particular
20 type of problem, is that what you are trying to get at?
21 A. Yes, so the main specialist provision within residential
22 is children with disability, and whilst we have had
23 children impacted by disability, we actually, one of the
24 units that we built in Pollok actually, all of the units
25 have a DDA compliant room, so that children who are

1 affected by disability can be looked after. And we
2 have, for example, undertaken adaptations to the house
3 in Pollok so that we were able to put hoisting equipment
4 in to look after a young person and keep them in
5 Glasgow. So at times we will be able to look after
6 children affected by disability within our own estate
7 and at times the scale of need in relation to their
8 disability means that we would need to purchase
9 a placement.
10 Q. But the staff in these houses that provide these
11 services, are they trained in a different way to other
12 residential care staff in houses in Glasgow?
13 A. When we have looked after a young person affected by
14 disability, we have had to undertake additional training
15 before the young people have been placed there and we
16 have been able to do that, but our staff are all SSSC
17 registered and have to be qualified as residential child
18 care practitioners.
19 Q. That's a difference, clearly, from the times of Kerelaw
20 and the times of Larchgrove --
21 A. Yes.
22 Q. -- where unqualified staff were allowed or were
23 employed, often in considerable numbers?
24 A. Yes, very different.
25 Q. SSSC require residential care workers to be

1 registered --
2 A. Yes.
3 Q. -- they require them, at least, not necessarily when
4 starting but certainly within a period of time, to
5 obtain certain minimum qualifications --
6 A. Yes.
7 Q. -- to be residential care workers?
8 A. Yes.
9 Q. As a condition of registration?
10 A. Yes.
11 Q. But these qualifications are not necessarily specialist
12 qualifications, they are things like SVQ 3 and HNC
13 qualifications; is that right?
14 A. Yes, although the senior practitioners and then the unit
15 managers all have to have additional qualifications and
16 the unit managers have to be educated to degree level as
17 well as have their residential child care.
18 Q. The front line staff is SVQ 3 and HNC, is it?
19 A. Yes.
20 Q. In social care?
21 A. Yes.
22 Q. That doesn't necessarily mean they could walk into one
23 of these houses that needs to cater for people with
24 particular specialist needs?
25 A. No, and that's why at points we have undertaken

1 additional training, and also our induction training, so
2 there isn't anybody that starts with Glasgow City
3 residential who is working towards a qualification, we
4 require you to be qualified work to with us. In our
5 induction training, people undertake induction training
6 prior to, excuse the vernacular, going on the floor, so
7 prior to actually having any interaction and being
8 a residential practitioner.
9 Q. So any residential care worker before they are let loose
10 have induction training?
11 A. Yes.
12 Q. Which is again a difference from the historical position
13 in Kerelaw --
14 A. Yes.
15 Q. -- or Larchgrove?
16 A. Yes, very different.
17 Q. Did you say there, and maybe I picked this up wrongly,
18 that do they have to have the minimum qualifications --
19 A. Yes.
20 Q. -- before they start the job?
21 A. Yes.
22 Q. You don't take on people on the condition that within
23 a certain time they will achieve a qualification?
24 A. Not in children's residential services, no.
25 Q. But that is possible --

1 A. Yes.
2 Q. -- under the scheme --
3 A. Yes.
4 Q. -- but you don't do it?
5 A. We don't do that.
6 Q. But other authorities might do that?
7 A. I am not aware of what other authorities do in that, it
8 is the position for us in older people's residential and
9 care at home staff, but not in children's residential.
10 Q. So all of your residential care staff, when they start,
11 not only receive induction training from Glasgow --
12 A. Yes.
13 Q. -- the Partnership, these days, but they also have to
14 have the minimum qualifications?
15 A. Yes.
16 Q. And if they are going to go into one of these houses
17 with specialist facilities, they will need additional
18 qualifications --
19 A. Yes.
20 Q. -- before they are allowed to work with --
21 A. Yes.
22 Q. -- the young people?
23 A. Yes.
24 Q. Just in terms of the changes, you have outlined these
25 earlier, but I think you told the Inquiry when you were

1 giving evidence in the foster case care study that there
2 also has been a shift in focus in modern times to not
3 simply providing alternative care --
4 A. Mm-hm.
5 Q. -- where it is needed, but to focus on, and I think
6 I will just quote what you said:
7 'On optimising their welfare and development and
8 ensuring we can achieve the best outcomes for them.'
9 A. Mm-hm.
10 Q. So the modern approach is we don't just care for them --
11 A. Yes.
12 Q. -- we develop and try to achieve the best outcome. So
13 it is more than just the basic care that historically
14 was given, is that the way that things are seen these
15 days?
16 A. Yes, very much so, and I think in particular looking at
17 things like The Promise, that has been a really big
18 influence to us, around about the voice of children and
19 young people, and behaving as parents, and that kind of
20 constant challenge to us, how would you behave as
21 a parent, because that is in effect the role that you
22 are undertaking when we are looking after young people.
23 We also -- I am pretty I sure talked about it the
24 last time -- have undertaken a transformation of
25 children's services where we have halved the number of

1 young people who are actually in our formal care. We
2 have significantly supported an increase in kinship
3 care.
4 Q. So they are not under the care of Local Authority, or
5 not under the care of the Local Authority and away from
6 home?
7 A. They are not away from home, yes.
8 Q. Or if they are away from home they are with a relative?
9 A. Yes.
10 Q. That's the trend?
11 A. Yes, that's the trend. But within that it has also been
12 about focusing then on the quality of the care that we
13 do provide for young people who we do look after away
14 from home, and not in their own families. Particularly
15 in the children's houses and in residential care, how we
16 replicate that family life and those aspirations for our
17 young people around about their wellbeing, educational
18 aspirations, and outcomes. And again, working with the
19 young people about what it is that they need and want
20 and how they have to be heard.
21 Q. Because I suppose historically when we go to the era of
22 Approved Schools and List D schools, it was almost a one
23 size fits all. That people had varied needs but they
24 were all stuck in an Approved School and to some extent
25 subjected to the same regime and received the same type

1 of care?
2 A. Mm-hm.
3 Q. That's not the modern way?
4 A. No, it's not. No, it's not. And going into our
5 children's houses now it does feel like going into
6 a family home and it is very much based around about the
7 individual needs of children and young people.
8 A particular issue for us emerging is the number of
9 young people that we look after who have some form of
10 neurodiversity and therefore we have to work really hard
11 in terms of being able to understand the impact that the
12 environment and their experiences are having on them.
13 And then how that manifests itself in terms of their
14 behaviour.
15 Q. And in terms of supervision of children in residential
16 units or houses within Glasgow, do I take it that today
17 all children in such settings who are the responsibility
18 of Glasgow City Council are supervised by a social
19 worker?
20 A. Yes, so all of the children will have their own social
21 worker who is responsible for their assessment care
22 planning and working with them. Then they will have
23 a key worker in terms of --
24 Q. Within the setting?
25 A. Yes, within the children's house they will have a key

1 worker, so they have a social worker and a key worker.

2 And we have also, in the last five years, developed

3 independent reviewing officers. So we have a team of

4 people who have got responsibility to have that sort of

5 additional eyes and ears in terms of making sure that

6 care plans are developed, are implemented, and reviewed.

7 Q. I think you told -- I mean I did have a look at what you

8 said in foster care, and I think you did mention this

9 additional layer of the independent reviewer, and

10 I think you say that, or I think you told us, or told

11 the Inquiry, that one of the things that perhaps is

12 being done now that wasn't done in the past was some

13 work on looking at the reasons and causes of placement

14 breakdowns?

15 A. Yes.

16 Q. Including breakdowns in residential care placements?

17 A. Yes.

18 Q. In order to perhaps understand why things have gone

19 wrong or not worked, is that the purpose, and it is done

20 in part with an independent individual looking at the

21 situation as part of a review?

22 A. Yes.

23 Q. Is that the standard way to do things now, if there is

24 a breakdown?

25 A. Yes, but also if there is a risk of a breakdown, so the

1 breakdown in residential placements in terms of our own
2 houses is almost non-existent now. So we have
3 significantly changed, and the number of young people
4 who have three or more placements has almost halved as
5 well. So we have a much more stable population, so the
6 support that we have to give to the staff and the
7 children in children's houses now is so where there is
8 a risk of breakdown, actually working through that to
9 prevent breakdown rather than facilitate a move.
10 Q. So it is preemptive in one sense --
11 A. Yes.
12 Q. -- but if there is a breakdown, I take it there is also
13 a review of why it broke down?
14 A. Yes, yes.
15 Q. That would involve, would it, the discussions and the
16 views of the child?
17 A. Yes it does, yes.
18 Q. Because historically and you will know this from looking
19 at the many statements that have been circulated by this
20 case study, that many young people had multiple
21 placements --
22 A. Mm-hm.
23 Q. -- both foster care and residential care placements,
24 over the years --
25 A. Yes.

1 Q. -- of their childhood?
2 A. Yes, and that's something that we have worked really
3 hard on and had some real success in terms of
4 decreasing, because we do recognise that the impact of
5 that multiple placements and the reinforcement,
6 particularly of earlier childhood trauma. So that's
7 something that we have been successful in reducing.
8 Q. I mean historically, no doubt, the theory or aim was
9 that the placement should be matched to the individual
10 child's needs --
11 A. Mm-hm.
12 Q. -- but historically I think we know that in many
13 instances, perhaps due to a lack of appropriate
14 provision and capacity within the system, that children
15 went where there was an available vacancy?
16 A. Yes.
17 Q. So there wasn't necessarily a good match?
18 A. Yes.
19 Q. Also, perhaps there wasn't the same degree of assessment
20 before placement?
21 A. No.
22 Q. These, presumably, would all have been factors that
23 would have played into an inappropriate placement?
24 A. Yes.
25 Q. And also the possibility that because you only had

1 limited facilities like Approved Schools, children with
2 complex needs were put into institutions which really
3 didn't have the ability to meet those needs, either in
4 terms of trained staff or the facilities themselves?
5 A. Yes. And they are smaller, because it is now they are
6 now six- to eight-bedded children's houses, we are
7 actually able to match much more effectively than we
8 have ever been.
9 And the other consideration is the cohort of young
10 people who are already living in a house, so it is as
11 much about the young person who may be required to come
12 in but also about that mixture of young people, because
13 you can have young people of very different ages and
14 at very different stages and sometimes that's a real
15 protective factor, because that's the reality of family
16 life, but sometimes you can have a young person where we
17 will make an assessment that to bring another particular
18 young person in there might increase risk or might ...
19 so we would look elsewhere within our estate.
20 Q. So you would look at the impact of introducing a new
21 young person --
22 A. Yes.
23 Q. -- into a relatively small residential unit --
24 A. Yes.
25 Q. -- and how that would play out the dynamics?

1 A. Yes.
2 Q. Yes, but these units do have young people of mixed
3 ages --
4 A. Yes.
5 Q. -- and different genders?
6 A. Yes, they are, yes, yes.
7 Q. They don't necessarily come from the same family?
8 A. No, no they don't, they come from, yes, from different
9 backgrounds, actually, and we have also more recently,
10 well, in the last ten years in the city, also had
11 an unaccompanied asylum-seeking population that at times
12 have had to be accommodated within our children's
13 houses. So there is a level of diversity in our
14 children's houses that we wouldn't have seen in the
15 past.
16 Q. Because, and no doubt we will find this out when
17 Mr Frizzell gives evidence to us tomorrow, that one of
18 the issues that was raised by staff at Kerelaw latterly
19 was receiving a large number of what was described as
20 emergency or unplanned admissions from Glasgow?
21 A. Mm-hm.
22 Q. Some described it as a dumping ground, because there had
23 been breakdown placements or other problems --
24 A. Yes.
25 Q. -- and that they ended up getting people, and not

1 necessarily getting them before assessing whether the
2 place was suitable?
3 A. Mm-hm.
4 Q. That was happening. You are aware of that, I take it,
5 that that came out of the report?
6 A. Yes, very much so. And again, that modernisation of our
7 own children's houses wasn't just about the physical
8 environment, it was also about working with the staff
9 and working to minimise those breakdowns. So, as I say,
10 we spend quite a bit of time supporting staff and young
11 people to hold on to, because the other thing you will
12 find is in actual fact as young people become more
13 secure if they have had that kind of childhood trauma,
14 or trauma in their family, you can actually start to get
15 an articulation of security through challenging
16 behaviours. So we have worked a lot with our
17 residential staff in terms of nurture training and in
18 terms of working with the young people and our
19 educational psychologist about understanding that, how
20 important it is to work through with young people that
21 point of challenge rather than to reject them at the
22 point of challenge.
23 Q. But there would still be a need for emergency
24 admissions --
25 A. Yes.

1 Q. -- they won't all just be placement breakdowns, there
2 will be emergency admissions presumably quite
3 frequently?
4 A. Yes.
5 Q. What do you do with them? If the theory is you want to
6 have careful assessment and careful placement, having
7 looked at the dynamics and all of the relevant factors,
8 but what if you need to place someone on an emergency
9 basis, where do they go?
10 A. So it is actually much less frequent than it used to be,
11 the emergency placements, and that's partly to do with
12 the work we are doing in the community. So we have, the
13 work that we did to half our population in care, we
14 reinvest in, we have got really significant family
15 support services, so we do tend to know the young people
16 that we are working with some risk in the community and
17 there is a risk of them coming into our care. So we
18 don't -- it was always traditionally late in the day,
19 late in the week, you would have a number of families
20 that we had maybe been supporting and that became
21 untenable. We have now got that support over seven
22 days, including weekends, including evenings, so whilst
23 we do have emergency placements it is much, much less
24 frequent than it used to be.
25 When I first became Head of Children's Services most

1 of the placements would take place on that kind of
2 context, and although we knew the young people well,
3 they weren't particularly planned. And that's the
4 opposite now.
5 Q. But if they do have to go, where do they go? Because
6 they could upset the dynamics of a small unit?
7 A. Yes, yes, so we would still look at substitute family as
8 well as residential. And we do -- we don't always have
9 our capacities at 100 per cent in the way in which it
10 used to be. So there is always some space within. If
11 young people have to come in on an emergency basis we
12 will do our best to match it. But ultimately, if the
13 risk is so great that we are making the decision to
14 bring them in, that's the risk that we have to respond
15 to first by bringing them in and keeping them safe.
16 LADY SMITH: When you say 'bringing them in', it could be
17 a matter of an emergency placement with a foster
18 family --
19 A. Yes.
20 LADY SMITH: -- or one of your homes within Glasgow, but
21 that has to be reviewed fast, to see if the child is in
22 the right place, I take it?
23 A. Yes, my Lady, it is reviewed within 24 hours.
24 LADY SMITH: Because we did hear in the foster care study,
25 you will remember, about, I won't say a habit, but too

1 many occasions on which a child is placed or was placed
2 with a foster family in an emergency and was still there
3 months later?
4 A. Yes.
5 MR PEOPLES: These houses that you have, you have told us
6 the maximum numbers, and I take it from what you have
7 been telling us that there hasn't been a problem of
8 overcrowding in recent times.
9 A. No, not in recent times no.
10 Q. Which was a historical problem?
11 A. It was, yes.
12 Q. With the big institutions?
13 A. Yes.
14 Q. Like Kerelaw or Larchgrove?
15 A. Yes.
16 Q. So you don't have that.
17 In terms of the composition within a unit, or
18 a house, if there are eight young people, say, how many
19 staff?
20 A. So just now we have somewhere in the region of 420
21 residential staff. You will have a unit manager, all of
22 the units have a unit manager, a senior residential
23 practitioner day and night, so you will always have
24 what's called a senior residential practitioner,
25 somebody who leads the team.

1 And at any one time during the day it will always be
2 three, and at night, depending on how many young people
3 you have, it can be two --
4 Q. So --
5 A. -- in residential.
6 Q. -- at any given time in a residential house there should
7 be at least three staff during the day --
8 A. Yes.
9 Q. -- and two at night?
10 A. Yes.
11 Q. That's the way it should operate?
12 A. Yes, and your unit managers would always -- unit
13 managers are there, generally, Monday to Friday, but
14 then within their contract we have an expectation that
15 during the course of the week they will be there on back
16 shift, they will be there of an evening, they will be
17 there at a weekend. So we have that expectation of
18 a unit manager. The job is not just a 9 to 5 Monday to
19 Friday.
20 LADY SMITH: In each 24-hour space how many shifts are you
21 operating?
22 A. Three shifts.
23 MR PEOPLES: You work a day shift, back shift, and a night
24 shift?
25 A. Yes.

1 Q. So there is a shift system of working?
2 A. Yes.
3 Q. For any one unit, how many staff are in the pool from
4 which the shifts are organised? You have three people
5 on duty at day, two at night, but how many are in the
6 pool?
7 A. I would need to come back to you on that, so I know the
8 overall 422, and 19 unit managers.
9 LADY SMITH: Do you have a feel for how many days in each
10 seven-day period these employees are working?
11 A. So most of them are on a 30- or 35-hour contract. And
12 the shifts are also different, you know, they are
13 different lengths, because we have a mid shift in some
14 of the units. There are also particular days where most
15 of the staff will come in, because that's when we expect
16 the staff meeting and supervision to take place. So it
17 is not a traditional rigid shift pattern, it is quite
18 flexible in terms of making sure that people, the young
19 people are supported but also the staff are supported.
20 LADY SMITH: It sounds like it is broadly speaking that
21 people are working four days a week --
22 A. Yes.
23 LADY SMITH: -- or it could be five, depending on how they
24 have worked out the shifts.
25 A. It wouldn't be five days, one after the other, my Lady.

1 LADY SMITH: No, I can understand that.
2 A. Yes.
3 LADY SMITH: Of course they may work fewer days the previous
4 week.
5 A. Yes.
6 MR PEOPLES: Is the unit manager in charge of simply one
7 house, or a collection of houses?
8 A. No, just one house.
9 Q. Yes, and does the Council, or the Partnership, employ
10 sessional workers?
11 A. No, not sessional workers. We have a peripatetic
12 residential team that are employed by us. And the
13 peripatetic team is about making sure that we have that
14 flexibility, particularly so we would use the
15 peripatetic team to cover absence or holidays, but
16 equally if there are young people that we are supporting
17 to try to prevent a placement breakdown we will put
18 additional staff in from the peripatetic team.
19 Q. So what you call the 'peripatetic team', are they full
20 time, or are they just on call?
21 A. No, they are full time.
22 Q. They are full-time employees of Glasgow?
23 A. Yes.
24 Q. I take it therefore there is a need for them to be
25 working on a full-time basis?

1 A. Yes, and it was also to bring them in line with all of
2 the training requirements. So they are a staff group
3 who are employed under the same terms and conditions as
4 our residential staff and we have the same expectations
5 of them.
6 Q. Because some -- and I happened to look at this -- care
7 providers to this day, I think do employ sessional
8 workers?
9 A. Mm-hm, yes, they do.
10 Q. You will be aware of that?
11 A. Yes, I am, yes.
12 Q. I just wondered how that worked in practice?
13 A. It was a practice that used to be in place, but we
14 didn't feel it was, in terms of the modernisation of the
15 workforce, it wasn't -- it didn't align itself with what
16 we wanted from our workforce.
17 Also in terms of how we would support them, and we
18 never use agency in children's residential, we have on
19 occasion had to use agency in our older people's
20 residential unit, but we have never used agency staff in
21 children's residential.
22 Q. The only disadvantage of a peripatetic team is that they
23 might go into a particular house as, to some extent, not
24 a familiar member of the team?
25 A. Yes, but because they are not sessional staff and they

1 are not agency staff, they have actually, they become
2 quite familiar with the units, and even some young
3 people -- because we do tend to hold on to our young
4 people and look after them -- will be familiar with
5 them.
6 Q. I suppose that, like any organisation, you will have
7 your fair share of sickness absences, so you will need
8 cover and the peripatetic team, one of the purposes is
9 to provide that cover?
10 A. Yes.
11 Q. If need be. Is that --
12 A. Yes, that's absolutely right, yes.
13 Q. Because the reason I asked you about the sessional
14 workers is that I think it is the case that certainly
15 people who were employed in Kerelaw, for example, such
16 as John Muldoon who, I think, started in the early
17 1980s, would have started as a sessional worker doing
18 some sessions and then would have graduated to at some
19 point becoming a full-time employee, and that was the
20 way things were done then?
21 A. Yes.
22 Q. I take it that wasn't an unusual situation in the early
23 1980s, that sessional workers were employed in that way
24 as and when required, and then they maybe worked their
25 way into a full-time position or a position as

1 a particular shift worker?

2 A. Yes, I think that was a feature, and one of the risks

3 there is then that people are not properly ... haven't

4 gone through a proper recruitment process --

5 Q. Yes.

6 A. -- and vetting process.

7 Q. Yes.

8 A. But, yes, that would be my recollection of the 1980s in

9 particular.

10 Q. In terms of shift working now, again, I think, no doubt

11 Eddie Frizzell will tell us this, but I think the

12 situation very much at Kerelaw at some point latterly

13 was that there was a night staff who were a constant

14 team and there was a day staff who were different

15 people, and never the twain shall meet except at

16 a changeover I think was the broad situation.

17 In terms of the shift system that operates in houses

18 now, do people work all the shifts at some point in the

19 rota?

20 A. No, because you still tend to have that difference

21 between particularly night shift and day shift. Again,

22 in my experience as an employer, as a provider of

23 children's residential services, you have to take

24 proactive measures to make sure that the whole of the

25 staff group in the children's house interact with one

1 another. So that we would have an expectation, for
2 example, that the staff meetings, that the night shift
3 would come to the staff meetings, they would be paid to
4 come to the staff meetings during the day. And in terms
5 of training, so the induction training that takes place
6 is across all of the shifts, and again that expectation
7 is that the unit manager is in regular visible contact
8 with the night shift as well as the day shift. But in
9 my experience it is something that, as a -- you have to
10 have, as I say, you have to be proactively engaged in,
11 particularly with your night staff, yes.
12 Q. But there is no distinction in terms then of either
13 induction training --
14 A. No.
15 Q. -- supervision, performance management --
16 A. No.
17 Q. -- training requirements, they all get --
18 A. Yes.
19 Q. They all have to go through the same --
20 A. Yes.
21 Q. -- mandatory training programmes?
22 A. Yes.
23 Q. Whether they are working a particular shift --
24 A. Yes.
25 Q. -- a night shift or a day shift, or whatever?

1 A. Yes.
2 Q. Do they all receive mandatory safe holding training,
3 I think that's the terminology these days?
4 A. Yes, when we submitted our addendum, so we had moved
5 from TCI to promoting positive behaviour, that's
6 a three-and-a-half day programme.
7 Again, we don't -- it was a feature in Kerelaw that
8 people weren't trained, but again you can't go on the
9 floor. So your induction training is before you
10 actually engage with any young people, and that includes
11 the three and a half days --
12 Q. I will come back to that --
13 A. -- of promoting positive behaviour.
14 Q. -- perhaps once we have looked at perhaps what happened
15 historically --
16 A. Yes.
17 Q. -- but I just wanted to know, and I think you are quite
18 right to say you have changed to promoting positive
19 behaviour in 2016 --
20 A. Yes.
21 Q. -- replacing what was known as 'Therapeutic Crisis
22 Intervention', is that right?
23 A. Yes.
24 Q. I will come back to that --
25 A. Yes.

1 Q. -- in due course.

2 As far as reviews of policies, practice, and

3 procedures in terms of residential provision, I think in

4 the context of policies, procedures, in the context of

5 foster care, you told the Inquiry that, and I think you

6 described there was, I think it was called 'Refresh

7 Them'?

8 A. Mm-hm.

9 Q. I take it that's a form of review, every two years to

10 make sure that anything that had come out nationally, or

11 there was any learning that should be reflected in

12 current procedures, could be introduced into the Glasgow

13 Partnership procedures and policies --

14 A. Yes.

15 Q. -- in practice.

16 Does that apply across the board to residential care

17 provisions as well, so there is now effectively a review

18 every two years as a minimum?

19 A. As a minimum. But there is always work going on, so

20 just now an example of that would be the work we are

21 doing with our education colleagues just now in terms of

22 nurture, because the nurture programme was something

23 that Glasgow City Education introduced in all their

24 schools. And in discussion with education there is

25 a real alignment with the promoting positive behaviour.

1 But there is specific training for nurture, for
2 teachers, so our educational psychologist now have
3 trained all of our residential staff in relation to
4 a nurturing approach to looking after young people. So
5 that's an example where you wouldn't -- that was an idea
6 that education brought to us, and you wouldn't wait
7 two years to do that, so, yes, it was something that we
8 took up immediately.
9 Q. So yes, it is not just everything stays the same for
10 two years, if there is a reason you will look at
11 something --
12 A. Yes.
13 Q. -- and you may change either the training programmes or
14 you may change a particular policy or you may change
15 a particular process or procedure?
16 A. Yes, and the other -- sometimes what would trigger that,
17 for example, would be the Care Inspectorate coming into
18 our children's houses. So we take all of the Care
19 Inspectorate reports, we are obviously doing
20 an individual action plan, but we also report quarterly
21 on any inspections that have taken place and any themes
22 that might be arising. So quite often we will find that
23 that might trigger either another look at a policy and
24 procedure or a look at what's going on somewhere else
25 across Scotland. That's another way in which there is

1 that kind of constant refresh, or consideration.
2 Q. Yes, although I suppose, I mean historically I think one
3 of the criticisms that the Kerelaw report brought out
4 was that while there may have been complaints, and there
5 may have been investigations of complaints, and there
6 may have been some degree of action on the complaints,
7 and following investigation, there was really no one
8 taking a grip of the overall picture, the bigger
9 picture, and whether the number of complaints and the
10 nature was telling you something that needed to be
11 looked at on a wider basis?
12 A. Yes.
13 Q. But that's changed?
14 A. That's changed quite substantially, so we now do ...
15 there is a review of all of the complaints, there is
16 a review of anything that comes to the Children's Rights
17 Service, so we do that, and there is a Children's Rights
18 report in terms of the themes that young people are
19 bringing there. And then the Care Inspectorate reports
20 we formally report into our finance audit scrutiny
21 committee quarterly, and that goes through the social
22 work professional governance board.
23 So there is an oversight and a scrutiny of that
24 triangulation of Children's Rights, of the Care
25 Inspectorate, and complaints.

1 Q. When looking at child protection and safeguarding, does
2 the Partnership keep in mind that inspections rarely
3 detect abuse?
4 A. Yes. Yes.
5 Q. Because I think there may have been an assumption in the
6 past that an inspectorate had some sort of function that
7 would, that you could be, you could see them as the
8 people that would tell you if there was a problem --
9 A. Yes, yes.
10 Q. -- in terms of treatment of children?
11 A. Yes.
12 Q. I am not saying that they didn't do it if they found it,
13 but I think we have seen that that didn't happen very
14 often --
15 A. Yes.
16 Q. -- and it is not actually seen as a function that they
17 investigate particular complaints or look at trends of
18 complaints, they will look at a complaints book, no
19 doubt, and see what the process is, but they are not
20 really there to do all of these things, there is a lot
21 left to the organisation --
22 A. Yes.
23 Q. -- is that right?
24 A. Yes.
25 Q. Is that understood?

1 A. Yes, that is understood. I mean I think for us it is
2 part of the check and balance in the system. The Care
3 Inspectorate visits and the reports and their analysis,
4 but it is only one part of the checks and balances in
5 the system.
6 Q. Just at this stage, before we look at the historical
7 position, whistleblowing --
8 A. Mm-hm.
9 Q. -- which is, can be difficult --
10 A. Mm-hm.
11 Q. -- if you are blowing the whistle on a colleague, or
12 colleagues, with whom you are working and will continue
13 to work in the future. I presume that is recognised
14 within the Partnership and the Council?
15 A. Yes.
16 Q. The difficulties of blowing the whistle --
17 A. Yes.
18 Q. -- if you are a serving employee?
19 A. Yes.
20 Q. I mean often people say something after leaving
21 employment?
22 A. Yes.
23 Q. I think that may have been the case with Edinburgh
24 Secure Services --
25 A. Yes.

1 Q. -- but it is maybe less usual for someone who is still
2 working to feel confident that if they even want to
3 raise a concern that it is necessarily in their best
4 interests to do so. How do you really address that
5 issue, because it is still a live issue, I think, in
6 many different organisations, as you probably know?
7 A. Yes, so we have got in Glasgow City a formal
8 whistleblowing policy and procedure. And that can be
9 anonymous. And all of those whistleblowing
10 investigations are actually, they are dealt with by our
11 audit function within Glasgow City.
12 In addition, specifically within the children's
13 houses we have got external managers as well the unit
14 managers, so we have a team of external managers,
15 another check and balance in the system, whose job it is
16 to do announced and unannounced visits, to do an audit
17 of supervision, to do audit of care plans, to do the
18 safeguarding plans, and to make themselves familiar to
19 young people and staff.
20 So anybody working within the children's house has
21 got other ways of raising issues that are not, that
22 means they don't have to raise it specifically within
23 their children's house.
24 Q. Yes, because I am just asking at this point, because
25 I suppose that you are telling us what's changed since

1 the days of Kerelaw and the days of Larchgrove. And the
2 sort of issues we have been discussing, leadership,
3 external management, supervision, performance
4 management, recruitment of staff, training in staff
5 development, restraint, child protection, were all
6 matters that were canvassed, I think, to some extent in
7 both the inquiries that took place, the independent
8 inquiries in relation to these establishments. I think
9 you are probably aware of that --
10 A. Yes.
11 Q. -- having read them.
12 And they are still live issues today, these are
13 matters that have to be --
14 A. Yes.
15 Q. You have to be vigilant about?
16 A. Yes.
17 Q. And sometimes the problem is the need to change culture,
18 attitudes and practice?
19 A. Mm-hm.
20 Q. I think you will be aware that that's often been said,
21 a place has a particular culture, it needs to change,
22 the attitudes need to change, the practice needs to
23 change.
24 Looking at it today, what does the Partnership do to
25 change culture, attitude, and practice, if that's the

1 problem?
2 A. So it starts at recruitment. And I think a feature
3 previously of some of the other institutions that the
4 Inquiry is looking at is that work in residential child
5 care was seen as a job. And our recruitment processes
6 now in terms of children's residential services are
7 really focused on making sure -- making sure about
8 people's motivation and their value base in terms of
9 coming into children's residential, and that's
10 a positive choice, rather than a choice about a job. It
11 is this job, going into children's residential.
12 Equally, the registration requirements mean that
13 there is a level of training so that people understand
14 what's involved in looking after children in residential
15 care.
16 Then in particular that the training programmes,
17 like for us in nurture, like in promoting positive
18 behaviour, are very much about making sure that staff
19 working for us understand the focus of the children's
20 residential services looking after those young people,
21 and they are the centre of what we do.
22 And there is an alignment between people's
23 motivation and people's experience and people's skills
24 with looking after young people. So that need to be
25 able to understand young people, to be able to work

1 alongside them, and to be able to respond to challenges
2 is something that starts at recruitment. And I think
3 previously it -- working in some of the older
4 institutions was seen as a job with decent terms and
5 conditions and a good pension. And I think at the point
6 of recruitment that's significantly different now.
7 Q. But I suppose, and I am sure we may hear this tomorrow,
8 is that changing attitudes and culture and practice can
9 sometimes take a considerable period of time --
10 A. Mm-hm.
11 Q. -- in reality?
12 A. Mm-hm.
13 Q. I think there is good research that often says that,
14 that you can come out with good ideas and say this needs
15 to change --
16 A. Yes.
17 Q. -- but it is one thing to say it, it is another thing to
18 achieve it?
19 A. Yes.
20 Q. So how can you, perhaps, accelerate the process by all
21 the measures you have said? Do you see evidence that it
22 does change, all of these systems that you have
23 described, that where a culture had to change, it has
24 changed, for example, since Kerelaw?
25 A. Yes, I would -- I do think it's changed. As a social

1 worker who placed young people in Kerelaw, and -- so
2 I have had that direct experience of being in Kerelaw
3 and other institutions, and now going into one of our
4 children's houses, you are effectively going into
5 a home. You are going into someone's home and the
6 interactions between the staff and young people, the
7 confidence that the young people have in speaking to you
8 when you go in about the kind of daily living and what's
9 going on in the house, the staff's commitment to making
10 sure that young people have the best outcomes, but again
11 you wouldn't ever be complacent. I think I said that
12 the last time. Not underestimating that there are
13 people who are malmotivated towards children, and in
14 some instances those people might be attracted to work
15 in our sector to get access to vulnerable children. So
16 you always have to be alert -- you always have to be
17 alert to make sure that you don't have an emerging
18 culture or practice or people working with you that are
19 potentially malmotivated towards working with young
20 people.
21 Q. How about historical practices, because in the past
22 I think people who were employed in a different era find
23 it difficult sometimes to make the changes needed to
24 adjust to the modern era?
25 A. Yes.

1 Q. I think that may have been a problem at Kerelaw, and
2 possibly --
3 A. Yes.
4 Q. -- perhaps at Larchgrove too, if we go further back.
5 A. Mm-hm.
6 Q. So you have that challenge, do you not, where you have
7 a workforce that to some extent is what I would call the
8 old guard. It is fine maybe with the new guard, because
9 they come in with all of these -- with knowing that all
10 these things happen before they are let loose on the
11 front line --
12 A. Mm-hm.
13 Q. -- but what about the old guard, that must present its
14 own challenges, does it not?
15 A. The old guard still have, are required to go through the
16 training, so they are still required to be registered.
17 And they are supported. It is important to support
18 people in terms of understanding some of the challenges
19 that our young people will bring. Again, the unit
20 managers are really important there in terms of setting
21 the tone in relation to culture.
22 Q. So they are a key --
23 A. Yes, key.
24 Q. -- person in the system?
25 A. Yes.

1 Q. And if their attitude or culture or practice is bad, you
2 have a problem?
3 A. Yes.
4 Q. Because this isn't just a discussion about history here,
5 because obviously, as you know, there was a damning
6 report about Edinburgh Secure Services following
7 whistleblowing by a former employee and indeed such has
8 been the reaction that I think the service has closed
9 down.
10 A. Mm-hm.
11 Q. And a lot of the safeguard systems and procedures that
12 you have just described, and perhaps the recruitment
13 processes and policies, may well have been similar to
14 Glasgow's, but nonetheless there were serious failings?
15 A. Mm-hm.
16 Q. So what are we to take from that about the systems and
17 their effectiveness?
18 A. Never to be complacent.
19 Q. Not just being never to be complacent, but how effective
20 they are in practice, in terms of we have, you have
21 described things that happened now, or the way things
22 are done now.
23 A. Mm-hm.
24 Q. All I am putting to you is well, if you look at that
25 as --

1 A. Yes.

2 Q. -- perhaps an example, it may be proof that the systems,
3 however much they have improved from the past, haven't
4 always worked effectively, and over a long period of
5 time. Because Edinburgh was, I think we were looking at
6 something like a ten-year period and there was a Care
7 Inspectorate, there was no doubt an external management,
8 there was no doubt lots of policies about
9 whistleblowing, child protection, and all the rest, but
10 you still have a problem. So what do we make of that?

11 A. It would be difficult for me to comment on another Local
12 Authority.

13 Q. I am not asking you to comment on specifics, but I am
14 giving it as an example of something that take it from
15 me, there were problems --

16 A. Yes.

17 Q. -- despite all of these changes that exist.

18 A. I don't think all of the changes were implemented in
19 that particular set of circumstances and I don't think
20 there was an evidence base that there was oversight of
21 the implementation and I don't think there was oversight
22 of the expectation, and I think actually the evidence is
23 quite clear --

24 Q. Okay.

25 A. -- that there was something that wasn't done that should

1 have been done.

2 LADY SMITH: Susanne, can I take you back to what you were

3 saying --

4 A. Sure.

5 LADY SMITH: -- about recruitment, because I am wondering

6 whether the strongest focus has to be on the decision

7 making about who you allow into your workforce. And you

8 used the word 'job' --

9 A. Mm-hm.

10 LADY SMITH: -- which I am interested in. Do I take it from

11 that you are talking about people who are really just

12 wanting something to do to pay the bills, a job?

13 A. Yes, my Lady, part of my reflection in Kerelaw, some of

14 that based on the work that came out of Kerelaw, but

15 also my personal experience of being in Kerelaw, was

16 that working in Kerelaw was seen as a decent job.

17 LADY SMITH: Whereas you might be looking for people who see

18 the way they want to live their life as not simply

19 having something they go out to which is a job, but is

20 their vocation --

21 A. Yes.

22 LADY SMITH: -- or is a career --

23 A. Yes.

24 LADY SMITH: -- that they value and want to pursue and get

25 good at.

1 A. Yes.
2 LADY SMITH: Do I have it right? You really want the
3 vocation, career, people with an appetite for pursuing
4 a vocation or a career coming into your workforce?
5 A. Absolutely, my Lady, and part of the assessment process
6 in terms of recruitment is precisely that, because there
7 are methods, you know, evidenced methods in terms of
8 exploring people's value base, and exploring people's
9 motivation, and exploring people's vocation, and for us
10 it is about, yes, having the skills, but actually having
11 a motivation that's about young people, that's about
12 making a difference with and for young people, and you
13 can, there are ways of testing that at recruitment.
14 LADY SMITH: When you take somebody on, is there a period of
15 probation that they have to fulfil?
16 A. We don't have a period of probation in social work in
17 the way in which they have in education, my Lady. There
18 was a move to do that, to have a probation year for
19 social work social care, but that's not implemented at
20 this point in time.
21 LADY SMITH: Would it be helpful?
22 A. As an employer, yes, I think a period of probation, the
23 way in which it operates within education services,
24 would be helpful.
25 LADY SMITH: I was wondering about it not simply in terms

1 of, say it is a six-month probation --
2 A. Yes.
3 LADY SMITH: -- giving you the option at the end of the
4 six months to tell the person that they are not going to
5 have a long-term job with you, but it would also mean
6 that as an employer you put in place a system that you
7 are really going to rigorously watch and assess what
8 this person is like, how good they are, how good they
9 are likely to be, in a way that you might not have a
10 prompt to do that otherwise.
11 A. Yes my Lady, and I think the other issue for me and why
12 I would support a probationary period is people might
13 have the right qualifications, and part of the
14 qualification in terms of SVQ and part of the social
15 work qualification is placement experience, but until
16 you see -- again, very similar to education, until you
17 see somebody full time in the context of that work, it
18 can be difficult. People can have qualifications but
19 are still not suited to the job --
20 LADY SMITH: Thank you.
21 A. -- their work.
22 LADY SMITH: Thank you, Susanne.
23 MR PEOPLES: Yes, I don't want to get drawn into ESS, and we
24 will look at that, no doubt, in due course. But I think
25 you are suggesting at least that perhaps part of the

1 problem there was the policies and procedures and
2 processes in place were not in practice adhered to and
3 operated in the intended manner.
4 A. Mm-hm.
5 Q. I can get that, but I suppose that then raises another
6 question: how do you ensure that those who have to apply
7 these systems in practice do so, and do the jobs they
8 were asked to do? Whether external managers, internal
9 managers, front-line staff and the rest, because it is
10 no good just saying, 'We have got lots of policies', if
11 they are not doing the job.
12 A. No, I think that's right, and I think that then the
13 oversight, and it is is not just within social work, it
14 needs to be, for example, at a political level. So
15 there needs to be reporting, and to political
16 committees. My understanding, again not to dwell on
17 somewhere else, that that didn't happen either. So
18 there are layers, so some of it's internal to social
19 work, with that kind of external of the Care
20 Inspectorate and others, but then you should be
21 reporting into political committees, you should be, you
22 know, reporting in to the wider Local Authority.
23 Q. I get that, but I suppose, I am sorry, from bitter
24 experience that of reporting systems in large
25 organisations, and the context of inquiries, I think it

1 has sometimes been found that there is a filtering and
2 dilution from bottom to top, and at the end of the day
3 you ask yourself whether you get a true picture of
4 what's happening, and also whether the people at the top
5 really have any idea what's going on at the coalface.
6 That's an issue in a large organisation, is it not?
7 A. Mm-hm.
8 Q. That the top, the people at the top, do they really know
9 what's happening on a day-to-day basis, unless they walk
10 in incognito and have a look for themselves, which no
11 doubt's a good idea. Do you do that?
12 A. As somebody at the top of an organisation, I am really
13 clear about the mechanisms open to me to check out
14 what's happening on the front line. It does include
15 visiting the children's houses in this particular
16 instance, and a number of other visits that I do across
17 the service. But I don't actually think it is
18 impossible to be at the top of a complex organisation
19 like I am and not have a sense of what's happening on
20 the front line, and not have a sense of where things are
21 going well and where things are not going well.
22 I don't think -- well, I believe the opposite; if
23 you are doing this job well, you do know that, and there
24 are ways you can work.
25 Q. Is that not the very point? You have to be doing it

1 well, because if we go to the historical examples, there
2 was a corporation or a Local Authority with a governing
3 body, a senior management team externally, external
4 managers, but given the surprise reaction to things that
5 happened, for example, at Larchgrove when the story
6 broke, they didn't seem to have much clue what was going
7 on in reality and were shocked, they said, when
8 investigations revealed things that no doubt they
9 thought were appalling and should never have happened.
10 I am just trying to see if, you know, it is all very
11 good to say 'I will know' or people should know if they
12 are doing their job, but these are examples historically
13 of people maybe not knowing, and maybe it was because
14 they weren't doing their job?
15 A. And I think both -- in both Larchgrove and in Kerelaw
16 that was one of the findings of both of the reports, was
17 there was a failure in that senior management.
18 Q. But the problem is that there was a failure twice over?
19 A. Yes.
20 Q. A Local Authority in the early 1970s is found to have
21 failed in material respects. A Local Authority in 2009
22 is found to have failed in material respects and in some
23 respects in similar ways to the one in 1973. So no
24 doubt despite commitments to learn lessons, that doesn't
25 appear lessons were learned, or forgotten if they were?

1 A. I think there was some commonality but some difference
2 between the two, but I don't think there is
3 an inevitably that senior management would fail in those
4 circumstances in complex organisations, they tend to
5 know the circumstances --
6 Q. I --
7 A. -- but I don't think that is inevitable.
8 Q. Forgive me, I am not suggesting that it is inevitable,
9 but I am just pointing out that the purpose of
10 independent inquiries is no doubt to discover the facts
11 and perhaps make recommendations and perhaps then hope
12 that those recommendations will be heeded and that
13 lessons will be learned, and we often get these
14 statements made after major inquiries, and I am just
15 pointing out to you examples where, well, there was one
16 major inquiry in the 1970s and then another one in the
17 first decade of the new millennium and they are both
18 flagging up to some extent similar issues about
19 leadership, supervision, management, and so forth.
20 And you have to ask yourself well, that seems
21 evidence that lessons haven't been learned or embedded,
22 and maintained. Do you see the point I am making?
23 A. Yes, and I do think there is some commonality, but
24 I think there is also some differences. So I think one
25 of the main things for me in Kerelaw was the absence of

1 that oversight, and there were procedures and policies
2 that should have been followed and that weren't.
3 I don't think that was the case in Larchgrove, I think
4 there were systemic issues around about the lack of
5 policy and procedure and there not being a framework
6 within which properly to operate.
7 So I think that was one of the -- there are
8 commonalities but there were also differences for me.
9 Q. I am not suggesting they were identical situations but
10 we are talking about the big issues here that maybe bear
11 on whether a service is good and whether a service is
12 protecting its users sufficiently from the risk of abuse
13 and harm. So we are looking at things like the
14 leadership, the systems in place, how they operate in
15 practice and whether staff are properly recruited,
16 whether staff are properly trained, whether staff are
17 properly qualified, whether staff are properly appraised
18 and managed. I mean that isn't a 1970s/2009 difference,
19 these were all relevant in both eras.
20 A. Yes, and I think it is -- when the Frizzell report
21 comments itself on it wasn't just that commonality, the
22 Frizzell report comments on other inquiries that have
23 been into residential care, and some of the
24 commonalities, it wasn't just the commonality between
25 Larchgrove and Kerelaw, and I think unfortunately that

1 is a feature, it is the same in child protection,
2 unfortunately, that the lessons learned or the issues
3 that lead to risk can and have been repeated over the
4 years.
5 Q. Yes, because often the recommendations are similar to
6 previous recommendations --
7 A. Mm-hm.
8 Q. -- and it does beg the question well, you know, why does
9 it not lead to some change, and some improvement, that
10 means that these deficiencies don't recur and that
11 history doesn't repeat itself?
12 A. So the part of that that I can respond to is post
13 Kerelaw, and it is my contention that they have changed,
14 and that lessons have been learned. It is much more
15 difficult for me to comment on the space between
16 Larchgrove and Kerelaw and what lessons were learned and
17 what changes were made.
18 Q. Do you feel that these systems now, that for example are
19 young people taking advantage more now than they did in
20 the past of complaints systems, and are raising concerns
21 that perhaps historically they wouldn't have done? Are
22 you finding evidence of that?
23 A. In terms of complaints, yes, the use of complaints, but
24 also the way complaints are handled by our organisation
25 is quite different. So that reporting requirement that

1 I talked about and the outcomes and the themes have to
2 be reported. Complaints are also undertaken by
3 a separate part of our organisation.
4 But also before that, the children's rights and 'Who
5 Cares?' for example being in all of our children's
6 houses. So there is an advocacy which is as important
7 as complaints, because if advocacy is working right and
8 children and young people feel that they can be heard,
9 they can work -- you can work through a resolution
10 before it becomes a complaint.
11 Q. Yes, but I suppose a problem with the past, and Kerelaw
12 may be an example, is that it is all very well saying
13 the complaints are better handled now, if they are made.
14 A. Mm-hm.
15 Q. But I think the problem was that people weren't making
16 the complaints at the first instance, for one reason or
17 another --
18 A. Mm-hm.
19 Q. -- either because they didn't have confidence in the
20 system --
21 A. Mm-hm.
22 Q. -- or for some other reason. So we never got to test
23 how effective the system was, because it simply wasn't
24 seen as something that young people were prepared to get
25 engaged in?

1 A. Mm-hm.

2 Q. And that can be a problem --

3 A. Yes.

4 Q. -- so I am saying how do you -- is there evidence that
5 young people are more willing to use these procedures
6 that are now available? Do you have evidence of that?

7 A. We have got evidence of young people using the
8 complaints, where they are -- making a historical
9 comparison, it is by definition really difficult because
10 of what you have just said, because there is that
11 evidence that children and young people didn't use the
12 complaints system, because they didn't have the
13 confidence in it.

14 So, yes, we have evidence of them using the
15 complaints system, but also evidence of that advocacy,
16 because it does, in my opinion, sit alongside.

17 Q. You are saying that, but there were children's rights
18 officers and Who Cares? at the time of Kerelaw, and
19 indeed they were visiting the place from time to time --

20 A. Yes.

21 Q. -- but that doesn't seem to have prevented the situation
22 that arose, and was described in the Kerelaw report?

23 A. I don't think they were -- they didn't have the
24 capacity, it wasn't that they were actively not, but
25 there wasn't the capacity for children's rights and 'Who

1 Cares?' to visit on a regular basis, there wasn't the
2 capacity in the Children's Rights Service for them to
3 become familiar either with Kerelaw and the young people
4 in it.
5 Q. And is there more capacity?
6 A. Yes.
7 Q. Do they have adequate capacity now --
8 A. Yes.
9 Q. -- in terms of the number of children's rights officers
10 within the Partnership --
11 A. Yes.
12 Q. -- to cover all of the places that have to be covered
13 and to visit more often --
14 A. Yes.
15 Q. -- than in the past?
16 A. Yes.
17 Q. You are confident you have that?
18 A. Yes, in the children's houses, yes, absolutely and there
19 are young people's meetings that are actually convened
20 by Children's Rights and/or Who Cares? and we have both
21 the Children's Rights Service within our own
22 organisation and the commission service from Who Cares?
23 LADY SMITH: Susanne, if I was a child or young person
24 within one of your houses in Glasgow at the moment, and
25 I had a concern, how would I go about making the

1 complaint or raising the concern?

2 A. So there is various ways that would be open to young

3 people, my Lady.

4 There is -- within each of the houses there is a box

5 where young people can make a written complaint,

6 anonymously, or name themselves. There is access to

7 their key worker. There is access to the unit manager,

8 their social worker, the review, children's rights, and

9 the Who Cares? workers. So, because it has to be kind

10 of multiple ways, so that young people have got a number

11 of people that they can go and speak to, should they

12 wish to raise a complaint.

13 LADY SMITH: Is there anything such as a dedicated app that

14 they can use? Using their phone?

15 A. Not to my knowledge. But I would really need to double

16 check with the Children's Rights Service. But not to my

17 knowledge, I haven't seen anything like that.

18 LADY SMITH: I raise that simply because it is the way young

19 people communicate --

20 A. Yes.

21 LADY SMITH: -- about just about everything now.

22 A. Yes.

23 LADY SMITH: There may be a key lesson there as to find out

24 what makes communication easiest for young people in the

25 modern world.

1 A. Mm-hm.

2 LADY SMITH: In a year's time or ten years' time it might

3 not be the mobile phone, it might be something else.

4 A. Yes.

5 LADY SMITH: But that's the thing of the moment.

6 A. Yes.

7 MR PEOPLES: I hear what you say about all these different

8 avenues and opportunities to raise concerns.

9 Perhaps I can tell you that even convicted abusers

10 today have responded by saying, 'Well, I didn't do it

11 and there were so many opportunities to say if I had

12 done something and it would have come to light'. They

13 are saying that all of these things were there in the

14 days of people like John Muldoon and Matt George, and

15 they are using it in a way to their advantage, to say

16 well, I deny these things, because had I been doing

17 these things all of these different opportunities to

18 disclose, then someone would have disclosed or someone

19 would have seen what was going on, at least to some

20 extent. And yet they are saying that didn't happen, no

21 one was coming along and saying these things and they

22 are using that to some extent to their advantage.

23 Do you see the point I am making?

24 A. I think it is connected to your earlier point about the

25 importance of culture, so you can have systems and

1 process in place but unless you have a culture where
2 young people are valued and their voices are heard or
3 seen as important. Again, one of the key findings from
4 Kerelaw was ... about the culture was staff centred, the
5 culture there was about the staff being the most
6 important people. So for me in our children's houses
7 there is also ... it sits alongside the need for there
8 to be a culture about children and young people's voices
9 being important and being the centre of what we do and
10 why we are here.
11 And so I think the systems and processes to some
12 extent didn't work, because they interacted with that
13 culture.
14 Q. But do you have good evidence today that for example
15 staff, who are still working in a place, are willing to
16 raise concerns, even if it might come at some degree of
17 personal cost if they are raising concerns about
18 colleagues, either to do with their treatment of young
19 people or their practice. Do you have good evidence
20 that the processes that exist for staff to raise
21 concerns are being used and perhaps used a lot more than
22 historically, and that it is making a difference? Can
23 you tell us about that?
24 A. We have evidence of staff and young people and external
25 managers raising issues, identifying issues about poor

1 practice, and complaints, so it is not just from one
2 source. So yes, we have evidence from across a range of
3 people in terms of raising issues. But again, I suppose
4 it comes back to my point about constantly having to be
5 on alert, because in my experience, and I think
6 I mentioned this the last time I gave evidence, that
7 with all of them people who are malmotivated towards
8 children will not immediately be obvious. Some people
9 who are malmotivated towards children can present as
10 being really effective and job centred.
11 Q. I get that, but if you take for example the issue of
12 restraint, and whether it is done appropriately or not,
13 then that's a situation where you would like to think
14 that if there was historically restraints on a daily
15 basis, that someone, if they thought something was
16 wrong, they would have seen it --
17 A. Yes.
18 Q. -- and you would have hoped they would have said
19 something. But it doesn't appear that was what was
20 happening, certainly in the Kerelaw example, that people
21 weren't coming along and saying, until latterly, before
22 closure, that they were seeing things that they were
23 concerned about. Maybe that goes back to the point
24 about people finding it difficult to speak out or call
25 out colleagues --

1 A. Mm-hm.
2 Q. -- when they are working with them?
3 A. Mm-hm.
4 Q. That could be as true today as it was historically?
5 A. I think there was, again, the interaction with the
6 culture. I think also the very specifics about Kerelaw
7 being physically distant from some of those, so some of
8 what should have been protective factors around about
9 external management, for example, was really distant and
10 the kind of prevailing culture in Kerelaw. I would
11 suggest that that's not the case -- the children's
12 houses are all in Glasgow, the external managers are all
13 visible, the unit managers are visible, the -- so
14 somebody ... and it is also linked back to the point
15 about at the point of recruitment, you are being
16 recruited into our service to look after children, and
17 to do that job well.
18 Q. I am sure that was the aim in the 1970s and 1980s, when
19 some of the convicted abusers were recruited. I don't
20 think one would doubt the good faith of what you were
21 trying to get, but ultimately people were recruited who
22 we know --
23 A. Yes.
24 Q. -- were convicted of abusing a large number of children
25 at Kerelaw.

1 A. Mm-hm. Yes.
2 Q. So --
3 A. So what I am saying is I think there are a range of ways
4 in which it is quite different now, but never be
5 complacent, because with all of those checks and
6 balances, and with all of that in play, you can still
7 have people who are malmotivated towards children.
8 Q. Just before we have, perhaps, the break, just to round
9 this part off. So are you reasonably confident, without
10 giving guarantees, that if children in these houses had
11 a concern about their treatment, or if staff had
12 a concern about how a colleague were treating children
13 in these houses, that they would speak up, even if they
14 wouldn't have done so historically, are you confident
15 about that?
16 A. I am confident about that, but I wouldn't give
17 a 100 per cent guarantee --
18 Q. No, I --
19 A. -- for all of the reasons I have said --
20 Q. -- follow that.
21 A. -- but, yes, I am confident about that.
22 Q. The reason you are confident is what? Because of: the
23 range of practice; because we have changed the physical
24 environment; because we have all of the children's
25 houses in Glasgow; because our recruitment's different;

1 because our oversight is different; because our
2 oversight is detailed and is reported on a regular basis
3 across our organisation, including into the political
4 committees; and the ways in which people can raise
5 a complaint and/or whistleblow are many and varied,
6 there isn't just one route.
7 So I would be confident about that.
8 Also, I have spent quite a bit of time with young
9 people in our care, they are very vocal, they do have
10 a confidence, we have done some work through The Promise
11 in terms of participation workers, and I do have those
12 interactions with our young people. I would be
13 confident about them.
14 Equally I have those interactions with our
15 residential staff and would be confident about that. We
16 still have challenges in terms of our workforce, we
17 always will, I think, so I wouldn't underestimate some
18 of the challenges in the workforce. But yes, I would be
19 confident.
20 MR PEOPLES: That's probably a good time to --
21 LADY SMITH: I am going to take the morning break now, I am
22 sure you are ready for one, Susanne, if that's okay with
23 you. We will sit again in about a quarter of an hour or
24 so.
25 Thank you.

1 (11.33 am)

2 (A short break)

3 (11.48 am)

4 LADY SMITH: Welcome back, Susanne, are you ready for us to
5 carry on?

6 A. Yes, my Lady, thank you.

7 LADY SMITH: Thank you.

8 Mr Peoples.

9 MR PEOPLES: Thank you, my Lady.

10 Susanne, can I now move to Larchgrove. Perhaps
11 I can just begin with a very brief introduction.
12 Larchgrove, as I think we know, was a remand home until
13 1968, and had quite a long existence --

14 A. Mm-hm.

15 Q. -- before then. Then of course we had the Social Work
16 (Scotland) Act 1968, which effectively removed the
17 remand home type of institution, and indeed detention in
18 remand homes, which was a feature historically.

19 LADY SMITH: Yes, I think, Mr Peoples, just for the
20 transcript, it took until 1971 for the 1968 Act actually
21 to come into force and affect Larchgrove, is that right?

22 MR PEOPLES: I think the children's hearing system in
23 part 3, perhaps, but I think the actual legislation that
24 removed remand homes may have -- I am not sure.

25 LADY SMITH: It doesn't matter.

1 MR PEOPLES: Perhaps not important for present purposes, but
2 we can check that.
3 Certainly the 1968 Act made provision about removing
4 remand homes and I think the general idea was to set up
5 a system of residential establishments, including
6 residential schools. The idea, I think, was that what
7 had been Approved Schools, and became List D schools,
8 were to be phased out, hopefully fairly quickly, but in
9 the event didn't happen until 1986.
10 A. Mm-hm.
11 Q. Also I think there was what had been remand homes in
12 some cases became assessment centres, and Larchgrove was
13 an example of that. That it was, if you like, converted
14 from a remand home into an assessment centre --
15 A. Mm-hm.
16 Q. -- post 1968.
17 A. Mm-hm.
18 Q. That's correct, is it?
19 A. That's my understanding, yes.
20 Q. Larchgrove was at that time run by Glasgow Corporation
21 until 1975?
22 A. Yes.
23 Q. Then by Strathclyde Regional Council, following local
24 government reorganisation in 1975, until its closure in
25 I think 1987, or thereabouts?

1 A. Yes.
2 Q. That's the broad picture.
3 So it pre-dates the Glasgow City Council era?
4 A. Mm-hm.
5 Q. I think you have said you have read the report of the
6 independent inquiry that was set up in relation to
7 Larchgrove, which reported in 1973. Can I just ask you
8 this: had you read that report prior to the start of
9 this Inquiry?
10 A. No.
11 Q. Am I right in thinking you were Head of Children and
12 Families at the time of the Kerelaw inquiry, or --
13 A. At the time -- when the independent inquiry was
14 commissioned?
15 Q. Yes.
16 A. So I became Head of Children's Services as the internal
17 inquiry was coming to a conclusion.
18 Q. Sorry, I meant the independent inquiry, the
19 Eddie Frizzell led inquiry?
20 A. Yes.
21 Q. You had become Head of Children and Families by that
22 stage in 2006?
23 A. Yes.
24 Q. Because I think the Frizzell inquiry, or the Kerelaw
25 inquiry, was commissioned in 2007 --

1 A. Mm-hm.
2 Q. -- jointly by Glasgow City Council and the Scottish
3 government?
4 A. Yes.
5 Q. And it reported in 2009?
6 A. Yes.
7 Q. As far as that inquiry is concerned, or indeed any
8 previous investigations internally by Glasgow into
9 Kerelaw, do you recall anyone making any reference to
10 the independent inquiry into Larchgrove in 1973?
11 A. I don't recall any reference to it. And you will notice
12 in the independent inquiry that there is a reference to
13 a number of other inquiries, so I was aware of all of
14 them. I was aware of them, actually, through the course
15 of my social work training. I had never heard reference
16 to that inquiry in relation to Larchgrove.
17 Q. Obviously, I think Larchgrove itself had closed --
18 A. Yes.
19 Q. -- by the time you became a qualified social worker in
20 around the early 1990s --
21 A. Yes.
22 Q. -- but you hadn't heard of it?
23 A. No. Other inquiry reports which predated or was around
24 about the same time were well known.
25 Q. I suppose had you been aware of it, you might have felt

1 it was useful to at least read it to see what it said?
2 A. Yes.
3 Q. Yes.
4 A. Yes.
5 Q. Just, perhaps, then by way of introduction, can
6 I perhaps start with referring you to a front page of
7 the [redacted] on [redacted] 1973. The reference,
8 I will give our reference to bring it up?
9 A. Yes.
10 Q. It is SGV-000090752
11 This is really the start of the story about
12 Larchgrove, in terms of the independent inquiry.
13 I don't want to go through this in too much depth.
14 A. Yes.
15 Q. But what you see there is a front page headline of the
16 [redacted] on [redacted] 1973, which is headed:
17 'Shock probe at boys' home. Supervisor talks of ill
18 treatment.'.
19 I think a supervisor then was someone who was like
20 a residential care worker?
21 A. Mm-hm.
22 Q. This public reporting was reporting that a member of
23 staff at Larchgrove, called Frank Carrigan, who is
24 photographed at the top right-hand side of the front
25 page of the [redacted], had made certain allegations

1 about the treatment of boys at Larchgrove by staff and
2 that Glasgow Corporation had decided to hold
3 an independent inquiry into the matter. So that was
4 being reported publicly at that time.
5 And I suppose this might be an unusual situation,
6 given the discussion we had this morning earlier, that
7 this is actually a whistleblower who blew the whistle
8 while he was still working at Larchgrove?
9 A. Mm-hm.
10 Q. Perhaps not a common thing in those days, and maybe not
11 so common now, at least, but that's the situation,
12 that's how it got to, into the public domain, if you
13 like.
14 It may be a good example of the power of publicity,
15 because we see that as soon as the story hits the press
16 the response of Glasgow Corporation is to hold
17 an independent inquiry into the matter, given the
18 gravity of the situation. And given it is presumably
19 because a member of staff is raising these allegations.
20 A. Mm-hm.
21 Q. If I could maybe just go to page 217, the previous page
22 in this document. I think this is a follow up by the
23 [redacted] the following day, [redacted], and we see
24 the headline there is 'Stay away from work'. And the
25 person who has blown the whistle is told not to report

1 for duty. So already, perhaps, there are signs that
2 maybe was this a good career move to go public?
3 A. Mm-hm.
4 Q. Having reported this matter, and apparently he is, as it
5 were, excused from duty until 'the charges you have made
6 have been cleared up', is the way it was put in the
7 document, in the report. I think that there may be
8 something to the effect in what's -- I think there is
9 an indication in the report, perhaps it is in, I think
10 it is on page 200 and --
11 LADY SMITH: Just before you leave that.
12 MR PEOPLES: I am not going to leave it, perhaps I will come
13 back.
14 LADY SMITH: Before you leave the page, I see that the
15 whistleblower apparently said 'I am delighted',
16 according to the quotation under his photograph. What
17 was it he delighted about?
18 MR PEOPLES: That there was an inquiry. I don't think he is
19 delighted to have been excused, as we will see at some
20 point.
21 If we stay on that page, just before I go to the bit
22 I was trying to find, it is on another page, but if we
23 look further down to the bit that's headed 'Years of
24 trouble'. There is in the piece some information about
25 the history of Larchgrove, and it is reported that it

1 has been plagued with a series of problems over the
2 years, including murder, rioting, mass escapes, and
3 persistent overcrowding. It says:
4 'Since it was opened 21 years ago ...'
5 Just on that point, I think that your response to
6 the Inquiry, the A to D response, indicates that
7 Larchgrove has a much longer history, at least there has
8 been something on that site for a much longer period of
9 time, I think from the beginning of the 20th century, as
10 a house of detention, originally. But I think it is
11 true to say that there was some kind of new building,
12 perhaps, built on the site around the mid 1950s, and
13 I think that's perhaps what that's a reference to, so it
14 is not suggesting that Larchgrove --
15 A. Yes.
16 Q. -- in the broad sense was new in the 1950s. But you
17 also see that it says there that it is the only
18 assessment centre for boys in the city, and was designed
19 to look after a maximum of 74 boys. And it says that,
20 as at January 1973 there were 66 boys in its care with
21 a staff of 41. Do we see that?
22 A. Yes.
23 Q. Then it lists a list of what's described as recent
24 incidents.
25 A. Mm-hm.

1 Q. A near riot, it says, in 1964.

2 Followed by a mass escape attempt.

3 In 1968, two inmates escaped after assaulting

4 a female member of staff in the kitchens.

5 Same year the home was closed because of

6 overcrowding. I suspect that would be to new admissions

7 rather than --

8 A. Yes.

9 Q. -- closed outright.

10 1969, there is another mass escape of 11 inmates,

11 all later recaptured.

12 And it is reported that a 14-year old boy in 1969

13 was stabbed to death by another 14-year old in the

14 home's kitchen, and that the boy was sentenced, I think,

15 to five years. I think that's a reference to the boy

16 being convicted of culpable homicide and receiving

17 a five-year sentence in respect of that offence.

18 But we also see that the report says that as far

19 back as 1968 SNR [redacted] of the home,

20 Mr LRL [redacted], was warning about the dangerous

21 effects of overcrowding and staffing problems. So it

22 seems that there is quite longstanding issues, some of

23 which were being flagged up by SNR [redacted]

24 and that he had been warning about these effects.

25 I think we can assume that the warning was being given

1 to the Corporation --
2 A. Mm-hm.
3 Q. -- by SNR [redacted]?
4 A. Mm-hm.
5 Q. Just pausing there, if a similar situation arose today,
6 what would happen? A member of staff making allegations
7 against another members of staff, or members, wouldn't
8 be excused from duty or moved from post, would he or
9 she?
10 A. No, more likely it would be the other way round, so more
11 likely it would be a -- no, it would be a consideration
12 of the seriousness of the allegations and then whether
13 or not the people against who the allegations were made
14 against, whether or not it was safe for them to be at
15 work.
16 Q. There might be some form of precautionary suspension?
17 A. Yes.
18 Q. Not a disciplinary suspension?
19 A. No, precautionary suspension.
20 Q. Pending investigation?
21 A. Yes.
22 Q. Or possibly, depending on the situation, moved to some
23 other duties?
24 A. Possibly. There is always a discussion that takes place
25 between the external manager and the HR, in terms of

1 some consistency around about that. So that decision is
2 not left in-house, that's a decision for external
3 management.
4 Q. Just before leaving that page, clearly Larchgrove had
5 a troubled history?
6 A. Yes.
7 Q. As evidenced by what is reported here.
8 A. Yes.
9 Q. If we could go to page 216 at this stage, which is,
10 I think, again a piece from the [redacted] on the
11 [redacted] 1973 headed '"Cruelty" inquiry at council
12 home', and there are various allegations made. I am not
13 going to deal with them here. We will go to the report
14 and see what was investigated in a moment.
15 That report says, I think within it, at least at
16 some point, that, yes, in the final column on the
17 right-hand side. If you see, I think, go down to the
18 third paragraph, it says, the report says:
19 'Mr Carrigan, the whistleblower, according to his
20 information, that he first raised the matter with his
21 department 11 months ago but it was not until I started
22 making my views public that any action has been
23 started.'
24 A. Mm-hm.
25 Q. This is, I think, where I got the idea of the power of

1 publicity, but it does seem to have worked in this case,
2 do you see?
3 A. Yes, yes.
4 Q. So we have this, and he is, of course, excused from duty
5 and it is not apparent, I think, at that stage that any
6 member of the staff who was accused was excused duty.
7 I mean Larchgrove seems to have just trundled on with
8 the staff?
9 A. Yes.
10 Q. That would be different to what might happen today?
11 A. Yes, it would be different, yes.
12 Q. It seems a bit odd, looking at it through today's lens?
13 A. Very odd, yes.
14 Q. It is certainly not an encouragement to whistleblowing?
15 A. No. I know you said you would come on to talk about it,
16 but I think the report as well speaks to some of the
17 differences just in terms of the views of young people
18 and the voices of young people and the need for
19 corroboration.
20 Q. Yes, well, we will come to that in a moment --
21 A. Yes.
22 Q. -- but I suppose at least it does show that, if a member
23 of staff says something and goes public, there is at
24 least some chance that something happens, as happened
25 here, but it might have been a different story if

1 an ex-resident from Larchgrove had gone to press.
2 A. Yes, yes.
3 Q. I mean I think that's a reality --
4 A. Yes.
5 Q. -- is it not, at least at that time?
6 A. Yes, at that time.
7 Q. May still be, for all I know, but certainly at that
8 stage it might have been difficult to get a front page
9 or even a [redacted] piece of that type --
10 A. Yes.
11 Q. -- if it was simply a resident saying, 'This happened to
12 me'?
13 A. Mm-hm.
14 Q. I mean it does happen, I think we have examples, no
15 doubt, but that at least gave it perhaps an impetus that
16 it could be run as a story and it would perhaps
17 require --
18 A. Yes.
19 Q. -- some form of investigation by the Council or
20 Corporation.
21 I will come back to how the story unfolded, but
22 I will perhaps look at the report now, if I may, which
23 is at GLA.001.001.5357. Which should come up.
24 I think you may have a hard copy, I am not sure, if
25 you have one, or is it on the screen?

1 A. It is on the screen, thank you.

2 Q. You will see, and I think you will now, having looked at

3 the report before giving evidence, you will see it is

4 a report that was presented to the Social Work and

5 Health Committee of the Corporation of the City of

6 Glasgow on I think it looks like 25 February 1973.

7 A. Mm-hm.

8 Q. It was a report by Sheriff Ronald Bennett QC, and

9 Peter Righton, who I think was what you might call the

10 social care expert and Sheriff Bennett was the lawyer?

11 A. Yes.

12 Q. So it was kind of a match to get a bit of expertise on

13 both fronts?

14 LADY SMITH: There is a rapid response taking place here,

15 I see.

16 MR PEOPLES: Exceedingly rapid.

17 LADY SMITH: The newspaper reports were ████████.

18 Within a week the remit was drafted naming

19 Sheriff Bennett and Mr Righton, and they reported --

20 MR PEOPLES: In March.

21 LADY SMITH: -- February, end of February, 25 February.

22 MR PEOPLES: End of February, sorry, yes.

23 LADY SMITH: Just over a month later.

24 MR PEOPLES: Yes, it was pretty quick.

25 I don't think it takes too much difficulty working

1 out that part 1, which is concerned with specific and
2 general allegations, which were investigated by the
3 independent inquiry, has all the appearance of being
4 drafted by a lawyer. I will look at this in a moment.
5 Part 2, which is a much more discursive discussion
6 about responsibility for the state of affairs at
7 Larchgrove has all the appearance of being written by
8 someone who has social care practice and expertise,
9 namely Mr Righton.
10 A. Mm-hm.
11 Q. I may be wrong, but I think that's a probable way of
12 looking at matters, albeit it is a joint report.
13 A. Mm-hm.
14 Q. If we see it. I think the bulk of these allegations
15 were ones which had been made by Mr Frank Carrigan, the
16 supervisor.
17 A. Yes.
18 Q. I think that's clear from the report.
19 If we go to -- we see on page 1, going through to
20 page 2, I think we get told a little bit about the
21 methodology and how the inquiry approached their task.
22 And I am not going to ask, well, you can see there, and
23 I don't want it to be read at length, but I think you
24 can see that what the approach was, was to apply to the
25 allegations the standard of proof of a civil court of

1 law, balance of probabilities.

2 It was a fairly rigorous approach, because at that

3 stage it said, if we scroll down, I think from what we

4 have, if we can continue, it may be on page 2.

5 Yes, I think it is on page 2, the top of page 2, if

6 we go to that you can see that what would be required to

7 find an allegation proved was by the civil standard, but

8 also that any hearsay evidence would be ignored. Mere

9 suspicion would be disregarded. And that no material

10 fact was to be held proved unless it was corroborated.

11 In other words the evidence of a single witness, however

12 credible it seemed to be, and reliable, it would not be

13 sufficient unless supported by some other evidence.

14 LADY SMITH: Susanne, you probably also noticed in passing

15 that the two authors self directed that what they called

16 'trivial allegations' were to be ignored, but I don't

17 think they explained anywhere what they classed as

18 'trivial'.

19 MR PEOPLES: Yes, it wasn't, it perhaps didn't embrace

20 everything that Mr Carrigan had raised either with the

21 Corporation --

22 A. Yes.

23 Q. -- or indeed with anyone else, for that matter, or in

24 the newspapers, but ultimately they did investigate

25 30 specific allegations and considered some general

1 allegations as well --

2 A. Mm-hm.

3 Q. -- before turning to what I would call responsibility

4 for the state of affairs.

5 A. Mm-hm.

6 Q. If we stay on page 2 for the moment, we can see, can we

7 not, that the independent inquiry interviewed 53

8 witnesses, some more than once, in various locations,

9 and took up a total of 18 working days.

10 It then details the specific allegations that were

11 made. What I propose to do is not to look at every one,

12 but I will pick out some.

13 A. Mm-hm.

14 Q. They were not all found proved using the method that was

15 adopted, but certainly there was a number that were

16 found proved, and I will come to that at the end of the

17 day. There is a certain similarity between some of the

18 allegations that involved punching of boys on various

19 parts of the body. But if we look at the first one that

20 was found proved, that's allegation number 4, which, if

21 we can scroll down, we can just look at that one.

22 The allegation was that on one night in June 1971

23 a member of staff punched a boy all over because he was

24 thought to have had possession of a knife, that:

25 '... the boy became enraged and had to be forcibly

1 put in the cell.'

2 That's the language of the allegation, and

3 considered the cell. That he was thereafter threatening

4 and abusive to the staff but was not punished by SNR

5 SNR , Mr LQT . And that

6 Mr Carrigan was present on that occasion, according to

7 his evidence to the Inquiry. We will see in some of the

8 allegations Mr Carrigan reported he was not present.

9 A. Yes.

10 Q. He just conveyed what they were.

11 The approach is fairly succinct, but the approach

12 then is to kind of canvass the sort of evidence that was

13 before the independent inquiry. If we look at this

14 particular example, the boy in question clearly gave

15 evidence to the independent inquiry, some didn't, some

16 were invited and didn't give evidence at the end of the

17 day, but this boy did.

18 He said that the member of staff had found a knife

19 in the corridor, which he thought had been put there by

20 the boy, and that the member of staff punched him in the

21 ribs, but he added that he would not call it an assault.

22 That's how he responded. And it is recorded that the

23 boy had told the police that he only 'got a shaking'

24 from the member of staff.

25 The member of staff who was accused said that he

1 didn't remember the incident and indeed SNR
2 SNR didn't remember it either. So in that
3 state of matters the conclusion was that the inquiry
4 found the allegation proved to the extent that in the
5 circumstances narrated by the boy he was shaken by the
6 member of staff, but they regarded the allegation of
7 punching as an exaggeration. So it was partially
8 proved --
9 A. Mm-hm.
10 Q. -- based on an acceptance of certain evidence that the
11 boy had given, mainly to the police, I think, rather
12 than to the inquiry.
13 So that was proved against the staff member in
14 question.
15 If we go on to another proven allegation, at least
16 to an extent, if we go to number 6, which is on page 5,
17 and the allegation there is in September 1971, and
18 I think this is the same member of staff, in the course
19 of restraining a boy, a different boy, punched him
20 several times in order to subdue him. It is recorded
21 that Mr Carrigan was not present on this occasion.
22 So this may in fact be one of the few examples of
23 allegations that mentioning the word 'restraint', but it
24 does appear that it is a, if I could put it loosely,
25 restraint incident that is being described.

1 A. Mm-hm.

2 Q. An alleged assault in the course of that incident.

3 When it comes to rehearsal of the evidence, at least

4 in the report, it says that the member of staff's

5 position was that the boy had attacked him in the

6 face -- sorry, had punched him in the face, and that he

7 punched the boy once in the stomach to get him away.

8 And the finding, which may be open to

9 interpretation, is that the allegation was proved to the

10 extent of the member of staff's admission. I am not

11 sure -- there seems to be a suggestion of self defence

12 here, but it is a little difficult to be clear what they

13 were finding. But they certainly accepted that, as they

14 probably had to do, there had been a punch by the member

15 of staff, at least.

16 LADY SMITH: In the course of some restraint attempts.

17 A. Yes.

18 MR PEOPLES: That was another allegation that had been found

19 at least proved in the way described.

20 Then maybe we can move on to another, allegation

21 number 9, which is on page 6. That on 11 October

22 another boy, different from the ones we have been

23 looking at, who had been put in a cell for attempting to

24 abscond, received from SNR [redacted] many more

25 than the permitted maximum of six strokes on the

1 posterior.

2 I think we know, certainly leaving aside the issue
3 of whether the remand home rules were in play at that
4 stage, that regulations restricted corporal punishment
5 to a maximum of six strokes on the posterior, over
6 ordinary cloth trousers, if I remember the formulation.

7 You will see there that it appears from the report
8 that four members of staff, including Mr Carrigan, were
9 present on that occasion. You will see it is recorded
10 that none of those present agree with Mr Carrigan. So
11 there seems to be a conflict of testimony as to what in
12 fact happened on this occasion.

13 You will see that the inquiry looked at the
14 contemporaneous documentary records, in this case the
15 centre's logbook, which recorded that the boy in
16 question was put in the cell at 7.10 pm on the date in
17 question for attempting to abscond. So that seems to
18 have been a form of punishment for absconding for
19 whatever reason.

20 And that at 10 pm on the same day he received, and
21 it is recorded, six strokes on the posterior for being
22 disorderly and insolent. It then says that the boy
23 stated that he was hit about 14 times, and that his
24 buttocks were black and blue the following day. The
25 finding is:

1 'We accept the boy's evidence as credible, and as
2 corroborating Mr Carrigan and find the allegation
3 proved.'
4 That's a finding of excessive punishment contrary to
5 the regulations, which caused injury in the form of
6 bruising, which was still apparent the following day.
7 LADY SMITH: Can we just go back to item 7, because I would
8 be interested to know, Susanne, what you made of this.
9 I don't know if you remember reading it --
10 A. Mm-hm.
11 LADY SMITH: -- but this is where the allegation had,
12 I think, two aspects to what people were saying.
13 One was that if a particular boy tried to escape
14 again, staff would just close their eyes to it, and then
15 when he did get away and wasn't caught a particular
16 member of staff said 'three cheers'. And the Panel, the
17 two authors of the report, note that that member of
18 staff admitted he may have made that remark, but then
19 they say well, this was a natural and justifiable
20 reaction to the boy's escape.
21 A. Mm-hm.
22 LADY SMITH: Does that tell you anything about the culture
23 and attitudes of the time?
24 A. I think there were several elements in the report, and
25 even the description still of 'inmates' in the newspaper

1 report --

2 LADY SMITH: Yes.

3 A. -- I think speaks to the context in which Larchgrove was

4 operating, but also, yes, the staff's attitude, in that,

5 you know, a young person would be a troublemaker rather

6 than somebody who was troubled.

7 LADY SMITH: And it was good news if he was out of their

8 four walls?

9 A. Yes, but no sense of any risk to that young person, no

10 sense of any risk to him in running away, no sense of

11 any risk about what it was in the community that was

12 pulling him out, it could have been a whole range of

13 issues. But just no sense that the young person would

14 be troubled and/or that the staff would have any

15 consideration of the reasons behind.

16 LADY SMITH: Then going forward to anyone working in this

17 sector --

18 A. Yes.

19 LADY SMITH: -- on reading this report, what they see is

20 that a Sheriff and an expert in social care has said it

21 is okay to feel like that and articulate those sorts of

22 feelings about the children who have been entrusted to

23 your care?

24 A. Yes. Yes, my Lady.

25 LADY SMITH: Thank you. Sorry.

1 MR PEOPLES: Yes, it is said that the inquiry team regard
2 the remark made in private as it was -- so what,
3 I suppose one might say --
4 LADY SMITH: So.
5 MR PEOPLES: -- a natural and justifiable reaction to the
6 boy's escape. As if in some way people who escape are
7 troublemakers, they should be put in a cell.
8 There doesn't appear to have been any consideration
9 either by the inquiry or anyone else as to what may have
10 caused the person to abscond, and what may have caused
11 them to behave in the way they did. On that occasion
12 absconding, but it could be anything.
13 A. But also, just above that, so the members of the inquiry
14 team are saying that he is a troublemaker.
15 Q. Yes, they made a factual finding.
16 A. As indeed the factor.
17 Q. So they seem to be willing to see a person who absconds
18 as a troublemaker and it doesn't appear that was based
19 on any wider consideration than the fact he absconded?
20 A. No.
21 Q. It is telling, perhaps, not only about the attitude of
22 the staff, but perhaps to some extent the way in which
23 an investigation body looked at the situation, and
24 appeared to have some degree of sympathy for the staff
25 in this situation, and very little empathy for the boy.

1 Is that how you read it as well?

2 A. Yes.

3 Q. I suppose if this report was circulated to staff, they

4 might get a degree of reassurance that, well, you know,

5 we are not being criticised too heavily here, and that

6 they recognise some of the problems, and that there are

7 'troublemakers' in our midst, because we have people who

8 abscond?

9 A. Mm-hm.

10 Q. I suppose, just extrapolating, it wasn't unknown in

11 those days, and it still isn't unknown, perhaps, at

12 least in recent times that people regularly absconded

13 from places for one reason or another. So it wasn't as

14 if this was an isolated type of scenario then?

15 A. Yes, it has always been seen as a risk factor, it is

16 a reason why you should look at a place, if young people

17 are regularly absconding, whether or not there is

18 anything happening in the unit to push them out, or

19 whether there is something happening in the community to

20 pull them.

21 So it is always -- in my opinion, it should always

22 be seen as a risk that you need to look at if you have

23 absconsion rates.

24 Q. We have lots of evidence, I think, so far -- I don't

25 think I am misrepresenting -- that has said that people

1 who have absconded have often said they might give their
2 reason to us, but they might say that no one asked us
3 why we absconded and there was almost an implicit
4 assumption that they had done something that they
5 weren't justified in doing.
6 A. Yes.
7 Q. That seems to have been at least the historical way of
8 looking at things --
9 A. Yes.
10 Q. -- that no one thought there was a problem.
11 Am I right in thinking that people were told to
12 really think about this more closely by the
13 Roger Kent --
14 A. Yes.
15 Q. -- safeguarding review, that said it could be a pointer
16 to there being something wrong.
17 A. Yes.
18 Q. That was in 1997, the Kent safeguarding review?
19 A. Yes, that's correct.
20 Q. That was trying to maybe set the balance the right
21 way --
22 A. Yes.
23 Q. -- to say don't make assumptions --
24 A. Yes.
25 Q. -- people run away for the wrong reasons, it could be

1 that there is something there that causes them to run
2 away?
3 A. Yes.
4 Q. Not always, but there could be?
5 A. Yes.
6 LADY SMITH: Susanne, did I hear you correctly in saying
7 that really in most cases the explanation could be
8 a push away from where they are because of something bad
9 happening there --
10 A. Yes.
11 LADY SMITH: -- or it could be a pull back to the community
12 they have come from, and so those responsible for the
13 children need to ask whether they have the child in the
14 right place if there is this overwhelming need in the
15 child to go back to the community.
16 A. It is go back to the community, but it is also
17 potentially that there are -- so in more recent years we
18 have had to be really alert to the fact of, so for
19 example sexual exploitation, or criminal exploitation of
20 young people --
21 LADY SMITH: Of course.
22 A. -- in our care.
23 LADY SMITH: Yes.
24 A. Certainly within the city we have implemented the
25 traffic light system with Police Scotland, so that as

1 soon as a young person hasn't come back home at the time
2 that we would have expected them, that we have
3 a protocol with Police Scotland, because we have had
4 issues at different points where our young people are
5 more vulnerable to sexual and criminal exploitation, and
6 we need to be really alert to that. So sometimes it is
7 not what's happening in the home, it is actually people
8 actively pulling our young people into.
9 LADY SMITH: Thank you.
10 MR PEOPLES: Just on that, I maybe should have asked you
11 earlier, in your houses today, presumably there will be
12 some young people who will be given the opportunity to
13 go home?
14 A. Yes.
15 Q. Is there a full risk assessment of that before the
16 decision is made that they can return home, or not?
17 A. So the decision in terms of going home is part of the
18 review, so it is always agreed as part of the care plan.
19 Sometimes it is parents, sometimes it is other family
20 members, so, yes, there is a --
21 Q. But is it a risk assessment, rather than a common --
22 because obviously risk assessment I don't think
23 historically was something that was done before home
24 leave in Approved Schools, for example, took place.
25 They were just sent away on a Friday night, given a bus

1 fare or whatever, and they came back on a Sunday --
2 A. Yes.
3 Q. -- and basically what they did in between wasn't
4 considered --
5 A. Yes.
6 Q. -- in most cases. There was nothing, they might have
7 been denied home leave because of their behaviour in the
8 institution, but not because someone said it wouldn't be
9 wise to send them home.
10 A. Yes.
11 Q. Is that different now? Is there a risk assessment or is
12 it not as high as that?
13 A. We wouldn't call it a risk assessment, because it is
14 part of the care plan. And it is -- because the
15 language is important, and it is important that young
16 people don't see their own families as risks, but they
17 see them as a strength, potentially. So it is just
18 an issue of language.
19 Q. It is language, but there is consideration given to the
20 consequences --
21 A. Yes.
22 Q. -- the potentially harmful consequences if the young
23 person goes home, either in the home itself or in the
24 community that they go to?
25 A. Yes, yes, yes.

1 The other thing is that it is never used, and it is
2 quite explicit that it can't be used as a sanction, so
3 planned contact with family cannot be used as
4 a sanction, to withdraw it --
5 Q. Yes.
6 A. -- from a young person.
7 Q. Because I think historically --
8 A. Yes, it was.
9 Q. -- that was one of the sanctions?
10 A. Yes, it was.
11 Q. It was seen as a privilege to go home --
12 A. Yes.
13 Q. -- and if you did something wrong in the institution it
14 was one of the things that was withdrawn?
15 A. Mm-hm, yes. It is quite explicit it is no longer the
16 case, it is actually in our residential policy.
17 Q. If I go back to the report itself, then, if we look
18 at -- I was looking at allegation 9, I think.
19 A. Yes.
20 Q. Just one other point that could be made here about
21 sending signals, I mean obviously it has been found that
22 on this occasion at least SNR, who is SNR
23 SNR, has used excessive corporal
24 punishment in the presence of a number of members of
25 staff.

1 A. Mm-hm.
2 Q. If you are displaying leadership qualities, or trying to
3 be a role model, it hardly sends the right signal to
4 those you are leading, does it?
5 A. Yes.
6 Q. If they see this, and see this as acceptable?
7 A. They also didn't tell the truth.
8 Q. Well, they were disbelieved, the four, yes, the majority
9 were disbelieved in favour of Mr Carrigan and the boy.
10 A. Yes.
11 Q. I think there is a theme through this that insofar as it
12 was possible to do so the inquiry team generally found
13 the boys credible and if there was supporting evidence
14 they would find that the allegations were proved. There
15 was very few examples, there was an exaggeration point
16 with one, but I think in broad terms they make that
17 point at some stage, that they weren't disbelieving
18 boys, they just didn't find the corroboration that they
19 required.
20 That's always a problem, isn't it, where you have
21 one or more members of staff against one young person.
22 It can be a real problem if you make a complaint that
23 you say one thing if you are the young person and the
24 member of staff and colleagues may say something
25 completely different. It is quite difficult in those

1 situations to be confident you are going to be believed.
2 A. Yes, and I think the other thing that struck me was that
3 there wasn't any exploration by the inquiry team of when
4 Mr Carrigan had made an allegation and the young person
5 said no, it didn't happen, and/or I don't remember.
6 There wasn't an exploration of ... or that might be
7 unusual, or more investigation into that.
8 And I think that's -- so that's one of the
9 differences. So child care has come on to the point
10 where in actual fact the work that we would do would be
11 to believe, to start with believing the young person.
12 And you would spend more time than one interview. These
13 look like they were one interview, so you would spend
14 more time than one interview, because you would want to
15 explore why Mr Carrigan had said -- because he said
16 a number of things that were proven, and then he has
17 a set of allegations that he has made that the young
18 person said didn't happen. You would have wanted to
19 explore what that was about and whether that was about
20 the power balance or the culture in the place.
21 Q. The other thing that you might take from this is that
22 whatever the logbook said, the inquiry found something
23 different.
24 A. Yes.
25 Q. So that what was recorded wasn't what happened?

1 A. Yes.

2 Q. Because the boy said it was more than the maximum and it

3 left him with the -- it was done forcibly and it left

4 him with injuries.

5 A. Yes.

6 Q. And you would never get that from the log?

7 A. No.

8 Q. And the log would appear to be one which had an entry,

9 that, if you were testing against the relevant

10 regulations, you would say, 'Well, it looks like he has

11 been disciplined for a matter ...'

12 A. Yes.

13 Q. '... he has been given the maximum. There is nothing to

14 indicate that there is anything untoward about the

15 punishment being administered on that occasion by SNR

16 SNR .'

17 A. Mm-hm.

18 Q. So it is maybe revealing in that sense that what's

19 written down may not in fact accurately record what

20 happened?

21 A. Mm-hm.

22 Q. And that's an example?

23 A. Yes.

24 Q. I suppose we don't know what the boy may have said at

25 the time?

1 A. Mm-hm.

2 Q. But there doesn't seem to have been any record if he did

3 say something about the matter. He may not have

4 complained, of course.

5 A. Yes, he may not have.

6 Q. Because in those days it may have been tricky,

7 particularly if you felt that there were four members of

8 staff present and you didn't know that Mr Carrigan might

9 be one of the ones that's prepared to speak up for you

10 against his colleagues.

11 A. Yes.

12 Q. Which is perhaps a rare type of situation in those days?

13 A. I mean it did seem like it, reading the report. And

14 I know the report comments on Mr Carrigan at the end,

15 but I mean that specific set of circumstances, with SNR

16 SNR and the other members, or other

17 colleagues, were prepared to say that Mr Carrigan was

18 wrong.

19 Q. Well, of course the accusation was against --

20 A. Yes.

21 Q. -- SNR --

22 A. Yes.

23 Q. -- and it might not be a good career move to say,

24 went over the score', particularly where clearly

25 there was some form of denial --

1 A. Yes.
2 Q. -- at least that that had ever happened in such a way.
3 So it is maybe good to -- we see there, at least
4 from what is recorded, that we can maybe make some
5 assumption abouts how things were done --
6 A. Mm-hm.
7 Q. -- and whether they were correctly done or not --
8 A. Yes.
9 Q. -- and the value of recording --
10 A. Yes.
11 Q. -- at that stage at least?
12 A. Yes.
13 Q. If we go to another example, just try number 10,
14 I think, this is a slightly different situation, and it
15 may be more a matter of poor practice than abuse, but it
16 is maybe worth looking at, that in December 1971 the
17 allegation was that a highly distressed boy, whose
18 brother had died, was forced, as it is put, that's the
19 language of the allegation, into bed by several
20 supervisors and was later taken to a psychiatric clinic.
21 This was something that Mr Carrigan did not in fact
22 witness personally. The approach was to look at the
23 logbook records, and the entries disclose that according
24 to the record at least the boy had been violent and had
25 to be restrained. So this is another example of the use

1 of the word 'restrained' on various nights in December
2 and early January, and that on 8 January, indeed, he was
3 found wandering about at 12.10 am.
4 We get some idea of what the evidence given to the
5 inquiry was. SNR, Mr LRL, tells the
6 inquiry that the boy had to be restrained because he had
7 lost all control, that only necessary force was used to
8 hold him in bed. And a member of staff, who assisted
9 SNR, said that the boy was in a fit and
10 the staff knew about his brother's death. And the
11 conclusion of the inquiry was:
12 'We do not regard the treatment of this boy as
13 amounting to cruelty, but we consider that having regard
14 to his distress at his brother's death he was
15 insensitively and unsympathetically handled.'
16 So that was a finding at that stage. I suppose
17 bearing in mind what they found about Mr LRL's
18 conduct in October 1971, his evidence to the effect that
19 only necessary force was used might, to some
20 investigators, be treated as a matter of caution.
21 A. Yes.
22 Q. If he is saying one thing and relying on records and so
23 forth as well.
24 A. Mm-hm.
25 Q. That his suggestion necessary force only was used was at

1 least open to question.

2 A. Yes.

3 Q. Anyway, they didn't treat it, I think, as an act of

4 violence or cruelty, but they clearly considered it to

5 be poor practice.

6 LADY SMITH: They did identify something that would

7 certainly find importance nowadays, they term it

8 'insensitively and unsympathetically handled', and that

9 appears later, I think, in some of their findings.

10 Having no regard to why this boy might be really, really

11 disturbed, as the findings said, he had just heard that

12 his brother was dead.

13 A. Mm-hm.

14 MR PEOPLES: It wasn't as if there was a lack of knowledge

15 of that fact, it might at least have been mitigated and

16 said, 'well, we didn't really know about the

17 background', but they admitted, the staff seemed to

18 admit that they had the knowledge of the situation and

19 still dealt with matters as recorded.

20 A. I think as well it is the use of the language 'out of

21 control' when you read it, and it feels like it would

22 have been quite obvious that the young person was

23 distressed, that's not lost all control.

24 I think the other thing for me in the report is,

25 I suppose, Mr Carrigan is the difference between

1 somebody coming into do that kind of work as a vocation
2 and other people coming into do it as a job, because it
3 feels to me -- well, it looked to me that Mr Carrigan
4 could have reported this both on the basis of the
5 violence that was used by the staff but also because it
6 was ... precisely because it was unsympathetic to the
7 fact that his brother had died. So I read that as
8 Mr Carrigan seeing that as entirely inappropriate, both
9 in terms of violence but also in terms of a response.
10 LADY SMITH: He also has recorded what looked like
11 a situation getting worse.
12 A. Yes.
13 LADY SMITH: It started on 26 December, there were
14 occurrences on 27th, 6 January, and culminated in what
15 sounds like a catastrophic incident on 6 January.
16 A. Yes.
17 MR PEOPLES: There is a further series of allegations. If
18 we look at 11, which again seems to be an acceptance of
19 the evidence of a boy, and in December 1971, this
20 allegation 11, a member of staff used to shake a boy and
21 push him about. That Mr Carrigan said he witnessed
22 this. The boy himself seems to have told the inquiry
23 that on one occasion this member of staff slapped him on
24 the back of the head. The member of staff himself
25 didn't remember the boy and didn't remember any incident

1 at all.

2 The conclusion reached on that allegation was that

3 the inquiry team accepted the boy's evidence as true and

4 find the allegation proved to the extent described by

5 him. Which seems to be that he had been slapped on one

6 occasion on the head, on the back of the head, rather

7 than just shaken. So that's what I take, but it is open

8 to ... I think that's what they were finding, if that

9 was his evidence.

10 Again, they seem to be at least there was

11 a willingness on the part of the independent

12 investigators --

13 A. Yes.

14 Q. -- to accept evidence of a young person making

15 an allegation against an adult member of staff --

16 A. Mm-hm.

17 Q. -- in a situation where it appears -- well, this was

18 witnessed, of course, by Mr Carrigan, that may have made

19 the difference as well, there was the support that they

20 found. So they maybe were reassured that he was being

21 supported --

22 A. Yes.

23 Q. -- by a member of staff.

24 A. Mm-hm.

25 Q. Although I think we will see later on there was

1 an occasion where another boy provided support --
2 A. Yes.
3 Q. -- and that was also accepted. So they seem to have
4 been willing to believe, if I can put it that way, that
5 these things did happen.
6 A. Mm-hm.
7 Q. If we go to, and I am not going to labour this one,
8 allegation 15, is this another finding of insensitive
9 and unsympathetic handling, where a boy is said to have
10 been slightly spastic and had been admitted to the
11 centre in [redacted] 1972, was distressed because he
12 thought his mother did not know where he was, and asked
13 for permission to telephone her and was refused
14 permission. And that the boy asked for treatment for
15 his foot, which he didn't receive.
16 And the finding there is that the investigators
17 found it proved that the boy was denied permission to
18 telephone his mother and was much upset and that his
19 request for hospital treatment was refused, and they
20 took the view, as they had done in the previous case we
21 looked at, that the boy had been insensitively and
22 unsympathetically handled.
23 Again, it might be a clue to the attitude to
24 requests by boys which on the face of it seem perfectly
25 reasonable and compelling, do you agree?

1 A. Yes, and in actual fact it is the denial of basic health
2 treatment, you know, it is not just insensitive and
3 unsympathetic --
4 Q. Yes.
5 A. -- and also basic child care, about not understanding
6 that young person's connection with their mum and how
7 important that would be. To think -- and he was
8 obviously really distressed, so to be presenting as
9 thinking your mum doesn't know where you are, and not to
10 have a human response to that, actually would be ... it
11 feels to me like a commission rather than an omission.
12 LADY SMITH: Yes.
13 MR PEOPLES: Also they do find instances of what they
14 describe as neglect of duty and arguably if you denied
15 a reasonable request for treatment that could have been
16 perhaps characterised in that way, rather than the way
17 that they have done.
18 A. Yes.
19 LADY SMITH: This is also a disabled child.
20 A. Yes.
21 LADY SMITH: The description is what we probably would now
22 be describing as cerebral palsly.
23 A. Cerebral palsly.
24 MR PEOPLES: Yes.
25 LADY SMITH: A form of cerebral palsy.

1 MR PEOPLES: It maybe also shows the variety of children
2 that were placed as a group in one setting, a remand
3 home, now assessment centre, where perhaps it goes back
4 to nowadays maybe a more discriminating approach to
5 placement would be appropriate, not just to lump
6 everyone together and treat them as some sort of
7 homogeneous group, they should all be treated in the
8 same way.
9 A. Yes, he was nine.
10 Q. He was nine yes, he was very young. But I think
11 Larchgrove was taking boys between 8 and 16 --
12 A. Yes.
13 Q. -- probably at that stage, generally speaking.
14 A. Yes.
15 Q. Then if we look at -- I think there is, well, this
16 perhaps is ... maybe if we look at allegation 18, just
17 briefly.
18 This is an allegation that in June 1972, at
19 a breakfast line up -- I think there were observations
20 about breakfast line ups later on that we will come
21 to --
22 A. Mm-hm.
23 Q. -- that a member of staff punched a boy in the stomach,
24 winding him, and this was ... Mr Carrigan said he was
25 present when this happened, so it was witnessed by

1 a member of staff. This was found proved. It said the
2 boy corroborated Mr Carrigan's statement, so he
3 presumably spoke to this happening. And on this
4 occasion it looks like the member of staff, it wasn't
5 a case of, 'I don't remember' this was, I think,
6 an outright denial of the incident in question. But
7 notwithstanding that denial, the investigators found the
8 allegation proved. But they seem to be ... they add at
9 the same time:
10 'We are of the opinion that this conduct on this
11 member of staff's part was an isolated incident and
12 quite out of character as we assessed him.'
13 They didn't say that about anyone else, I don't
14 think, but they were prepared to say it about one
15 particular member of staff. I am not sure on what basis
16 of assessment this additional call was made, but it
17 wasn't an endorsement of all of them. They were saying,
18 for example, that where SNR has been
19 found proved to have done something, excessive
20 punishment, this was completely out of character.
21 A. Mm-hm.
22 Q. It is just perhaps an odd one to say. But I suppose he
23 took comfort, the particular member of staff, by the
24 report when it came out.
25 So that's, I think, in passing one where it is at

1 least, it would appear, they are suggesting that this
2 didn't happen. At least with this member of staff, on
3 more than this occasion. But it is hard to tell.
4 If I can pass on, there is an example of a, I think,
5 something that maybe does represent a neglect of duty,
6 I maybe will pick that one up, if I may, allegation 20
7 on page 10. This is a boy who is admitted to the centre
8 in 1972 with burns on his left shoulder, sustained at
9 home. The allegation was he received no treatment for
10 three days. The logbook, according to that source,
11 Mr Carrigan wasn't on duty on the day of admission and
12 on the following day, ████████, he was not on duty in the
13 wing where the boy was placed. But he was on duty on
14 the third day, which was ████████ 1972. So this would at
15 least perhaps confirm his presence at least for part of
16 the period.
17 Then evidence from the depute matron was to the
18 effect that she had a report of treating the boy's burn
19 on ████████, which I think would be his third day of
20 admission --
21 A. Mm-hm.
22 Q. -- and the doctor is recorded as dressing the burn on
23 that day.
24 And the matron also gave evidence and told the
25 inquiry, I think, that she thought she may have dressed

1 the burn on either the second day or the third day, but
2 could produce no record. So she didn't have a record.
3 But she did say the burn was quite severe and should
4 have been detected when, I think the boy was admitted on
5 the day of admission. It says 'took a spray', is that a
6 shower, I presume?
7 A. I presume so.
8 Q. Took a spray. Well, it is difficult. I think it
9 might -- he may well have taken some form of shower --
10 A. Yes.
11 Q. -- and at least been examined to some extent --
12 A. Mm-hm.
13 Q. -- but in any event she is confirming at least that it
14 was something that should have been picked up as soon as
15 he came in.
16 A. Mm-hm.
17 Q. And the finding was that the burn was left untreated for
18 two days and this was considered to be evidence of
19 neglect.
20 A. Yes.
21 Q. So that's a neglect of duty, rather than unsympathetic
22 handling, so this was another form of allegation that
23 was found proved that had come forward from Mr Carrigan.
24 Then I will just look at 22, briefly, which starts
25 on page 11 of the report. The allegation was

1 in December 1972, on the 10th, a member of staff dragged
2 a boy out of a dormitory where he should not have been
3 and slapped and punched him. On this occasion
4 Mr Carrigan wasn't present, but he must have conveyed
5 this allegation to investigators. The boy gave evidence
6 to confirm that he was in the wrong dormitory. He said
7 the member of staff slapped him on the back of the neck
8 and punched him in the stomach, but not hard. The
9 person accused, and another member of staff who was
10 present, told the inquiry that they remembered the boy
11 being pushed back to his own dormitory but deny that he
12 was in any way assaulted by the person accused of
13 assault. So really it was down to the boy against the
14 evidence of two members of staff.
15 It is interesting how they put this matter, though:
16 'We therefore find there is no legal proof of the
17 allegation.'
18 I think as far as one can discern that's probably
19 saying well, applying our own rules, we couldn't accept
20 it as proved, that we can't find legal proof of what
21 happened, but we are not suggesting that the boy should
22 be disbelieved.
23 A. Mm-hm.
24 Q. That's the way, I think, you could read that.
25 A. Yes.

1 Q. It is the only way, I think, it is the only time it is
2 put that way.
3 LADY SMITH: They seem to find the boy was pushed.
4 MR PEOPLES: Oh yes.
5 LADY SMITH: But don't feel they can go as far as saying he
6 was assaulted.
7 MR PEOPLES: No.
8 LADY SMITH: Perhaps that's partly because of the limitation
9 of the boy's own evidence.
10 MR PEOPLES: Yes, it is perhaps the way it is couched.
11 A. Yes.
12 Q. They are not suggesting that this boy, or indeed a lot
13 of the other boys who came forward, or sorry, were the
14 subject of allegations in this case -- were the subject
15 of allegations that were made by Mr Carrigan, I should
16 say, were to be disbelieved?
17 A. I think the other interesting thing about that, because
18 I am sure it is more than once where the boys say 'it
19 wasn't hard'.
20 Q. Yes.
21 A. Again, there doesn't seem to be an exploration of --
22 they seem to accept, like, they are there to be
23 assaulted, almost, and that you grade it by how hard it
24 was. It wasn't actually the fact you were pushed or
25 punched, it was, well, it wasn't hard, because I am sure

1 that's more than once in the record.
2 LADY SMITH: We are not seeing their sense of the norm being
3 that they are not pushed around or hit at all.
4 MR PEOPLES: Indeed that might have been their norm, that
5 they got pushed around --
6 A. Yes.
7 Q. -- and perhaps in those days a slap was not seen as even
8 constituting some form of assault.
9 A. Yes.
10 Q. That was something that was acceptable, if it was -- or
11 a clip round the ear, despite regulations.
12 A. Yes. He also described himself as being in the wrong
13 place, almost as if this would be the justification.
14 Q. Then if we go to allegation 26 of the 30, the allegation
15 was on 26 December 1972, a member of staff, one that's
16 previously featured, injured the arm of a boy during
17 an argument. Again, Mr Carrigan in relation to this
18 allegation wasn't present.
19 The records showed that, for the relevant date, the
20 boy had a contusion of the left wrist and hand. The
21 matron told the Inquiry that it was swollen, I think the
22 wrist and hand, and she put on a cold compress, and
23 a sling. The boy said that the member of staff
24 deliberately twisted his arm and later punched him. The
25 member of staff who was accused maintained that the boy

1 was fighting, that he took the boy's wrist and that the
2 boy swung round, causing his wrist to be twisted. But
3 the inquiry found:
4 'We do not accept that the injury was caused in the
5 way described by the member of staff. We accept the
6 boy's account and find the allegation proved.'
7 I suppose that's an example of where, by the
8 admissions made by the member of staff, there was
9 sufficient to corroborate a boy who was considered to be
10 telling the truth.
11 A. Mm-hm.
12 Q. They were able on that occasion to find it and
13 disbelieve the explanation given by the member of staff.
14 A. Mm-hm.
15 Q. So he was fortunate, the boy, that there was some
16 corroboration, rather than 'no comment', which could
17 have put him in some difficulty?
18 A. Yes.
19 Q. Then if we can just pass over that there were more
20 allegations, but I can -- this is one which maybe,
21 allegation 28, which was an allegation that in
22 January 1973, which was that a member of staff kicked
23 a boy in the groin and punched him in the mouth with
24 a locker key, which was held in his fist. Mr Carrigan,
25 the whistleblower, wasn't present but said he gave

1 evidence that he saw the boy's mouth was cut.
2 The boy said that the member of staff accused had
3 hit his mouth with the arm when he turned around
4 suddenly to tell the boy to stop talking. The boy
5 didn't think the member of staff realised he had hit the
6 boy, and his lip was cut. So the boy was to some extent
7 exonerating the member of staff, but on this occasion
8 another boy who was present told the inquiry that the
9 boy had punched a small boy, that the member of staff
10 had said, 'How would you like me to punch you?' That
11 the member of staff then proceeded to punch the boy in
12 the mouth deliberately, and when he did so he had keys
13 in his hand.
14 The member of staff said that the boy had assaulted
15 another boy and was about to do it again. That he put
16 his hand out to stop the blow and that the boy's face
17 accidentally came in contact with the member of staff's
18 hand. He might have had a key in his hand when that
19 happened, and that previously that afternoon the boy had
20 called the member of staff 'a poof', and that the member
21 of staff kicked him lightly on the behind.
22 So that was the state of the evidence that they had,
23 and the investigators found that the witness, the boy
24 who was the witness, his account should be accepted, and
25 they didn't accept that the blow was caused

1 accidentally. And they found the allegation proved to
2 the extent of the punch and the admitted kick on the
3 behind.
4 So there the boy to some extent was supporting the
5 member of staff, but when they examined the whole
6 evidence, including what another boy had seen, they were
7 satisfied that it had in fact been a deliberately
8 inflicted injury on that occasion.
9 A. Yes.
10 Q. Then the next allegation, number 29, second last, was on
11 24 September 1971. SNR, on this
12 occasion, punished a boy who had absconded by
13 administering six strokes on his lower back, buttocks,
14 and thighs with such force that he was black and blue
15 for a fortnight. This is an allegation of excessive
16 force during corporal punishment administered by SNR
17 SNR. The boy spoke to this, the boy's family
18 told the inquiry of the area and severity of the
19 bruising that the boy had spoken about and the logbook
20 showed that on the date in question SNR
21 SNR had inflicted, according to the record,
22 four on the behind for absconding and for causing
23 damage.
24 SNR said only four strokes
25 were administered, and his position was that they were

1 properly administered. What the inquiry found was:

2 'We are prepared to accept that there may have been

3 only four strokes but we find that excessive force was

4 used and that the blow or blows on the lower back were

5 improper and dangerous.'

6 And that's SNR --

7 A. Yes.

8 Q. -- who is doing this and maintaining that everything had

9 been appropriately administered. He is maintaining this

10 to an independent inquiry, who disbelieve that, or don't

11 accept that.

12 A. Mm-hm. Yes.

13 MR PEOPLES: I see that it's 1 o'clock, it may be a good

14 time to stop.

15 LADY SMITH: I think we probably ought to break now.

16 Susanne, I will take the lunch break now and sit

17 again at 2 o'clock, if that would work for you?

18 A. Okay.

19 LADY SMITH: Okay, thank you.

20 A. Thank you.

21 (1.01 pm)

22 (A short break)

23 (2.00 pm)

24 LADY SMITH: Welcome back, Susanne. Are you ready for us to

25 carry on?

1 A. Yes, thanks, my Lady.

2 LADY SMITH: Thank you.

3 Mr Peoples, when you are ready.

4 MR PEOPLES: My Lady.

5 Good afternoon.

6 A. Afternoon.

7 Q. Before lunch we had been looking at part 1 of the

8 Larchgrove report, and can I just go back there and

9 continue for the moment in part 1. I think we were at

10 page 15, which is on the screen. I would just like to

11 refer to, we had just looked, I think, at the

12 penultimate allegation, specific allegation, in part 1,

13 which related to punishment inflicted by SNR

14 SNR .

15 A. Mm-hm.

16 Q. The conclusion was that excessive force was used by him.

17 So we have a situation where there are at least findings

18 against both SNR and SNR of

19 excessive force causing injury during the administration

20 of corporal punishment.

21 Then the final specific allegation is number 30, and

22 that was that on 10 January 1972 SNR

23 administered five or six strokes to a boy's bare

24 buttocks and left thigh, with such force as to cause

25 bleeding. It is another allegation of excessive force

1 during corporal punishment.

2 In relation to this allegation, the records

3 disclosed that on that date there had been a punishment

4 of six on behind for persistent defiance, so that was

5 the record. SNR said in evidence that he

6 agreed he must have administered this punishment, though

7 he couldn't remember having done so. So clearly it

8 wasn't memorable for him.

9 A. Mm-hm.

10 Q. But the boy did speak to the punishment in question, and

11 his mother and grandmother corroborated his account in

12 the sense that they told the inquiry they saw cuts on

13 his buttocks and thighs and dried blood on his

14 underpants and the inside of his trousers.

15 So in the light of the whole evidence the

16 investigation team found, or stated, that they

17 considered it proved that SNR had used

18 excessive force on this occasion, and that in view of

19 the cuts the boy's buttocks were probably bare at the

20 time. So they reached a conclusion on that part of the

21 allegation also.

22 So there's another example of SNR ,

23 who is running the centre, being found to have used

24 excessive force when administering corporal punishment,

25 and not only that, doing something that was at least not

1 permitted by the Remand Home (Scotland) Rules at the
2 time.
3 As far as the specific allegations are concerned, if
4 we -- I think it's on page 15, if we just read down
5 under 'summary' that of the 30 specific allegations it
6 is recorded that 17 have failed, and I quote, 'largely
7 for lack of corroboration'. This maybe underlines what
8 we saw earlier --
9 A. Yes.
10 Q. -- that it wasn't because in general terms the young
11 people were being disbelieved or the whistleblower being
12 discredited in the light of evidence of other staff.
13 If we go to page 16, and I will just perhaps
14 summarise it, I think they tell us that what was proved
15 using the method described in the report was that there
16 were nine incidents of violence shown by staff to boys
17 of varying degrees of severity and involving seven
18 members of staff. I think, doing a head count, it
19 involved eight boys, as well.
20 LADY SMITH: Yes.
21 MR PEOPLES: Two incidents involved neglect as it was put
22 and there were two incidents of what were described as
23 'unsympathetic handling'. So it was quite a catalogue
24 of incidents that were found proved, alleged incidents.
25 And, as we have observed, some were findings against SNR

1 SNR --

2 A. Yes.

3 Q. -- and SNR , as part of the

4 investigation.

5 This was during a relatively short period between

6 I think May 1971 --

7 A. Mm-hm.

8 Q. -- and January 1973 --

9 A. Yes.

10 Q. -- so we are not talking about an extended period of

11 time in this case.

12 So these were the specific allegations that were

13 found to have been proved.

14 Then there was also a look at some general

15 allegations that were also made, and that's also dealt

16 with in part 1. If we go to page 16 again, under the

17 heading 'General allegations', can we see there that

18 there was an allegation of a general nature that many of

19 the staff frequently shouted at the boys, pushed them,

20 cuffed them, shook them, punched them, and punched and

21 kicked them. So that was the general allegation. The

22 finding of the inquiry was, and I will read this out:

23 'There is ample evidence to support a clear

24 conclusion that shouting, pushing, cuffing, and shaking

25 frequently occurred, particularly at line ups and when

1 minor offences were committed. We find also that there
2 was sporadic punching and kicking. Mr LRL [that's
3 SNR] was aware of pushing and of
4 complaints of kicking and punching. He has told the
5 staff [this seems to be accepting his evidence on this
6 point] they were a bit rough as he puts it and told them
7 to use the minimum force in subduing unruly boys and
8 breaking up fights. Many of the staff plainly ignored
9 this instruction.'.
10 Then there is reference made to a rule 25.1(g) which
11 I think is a rule from the Remand Home (Scotland) Rules
12 of 1964, wherein it is expressly stated that striking,
13 cuffing, and shaking are strictly forbidden. So that is
14 recorded as part of the inquiry findings.
15 As regards bed wetting, there was an allegation that
16 when bed wetting occurred, which was said to be
17 frequent, boys were not always permitted to change their
18 sheets and pyjamas until the morning. And this
19 practice, apparently, was followed in particular by two
20 members of staff, who are named. It is said that one of
21 them would not, in addition, allow boys to go to the
22 toilet during the night. So that was the allegation.
23 And they then record the appropriate procedure, but
24 I will not read it out. I think we can read it for
25 ourselves, but at the end of the day they say, 'We find

1 this allegation proved'.

2 So they were satisfied that what was alleged in
3 relation to response to bed wetting and how it was dealt
4 with had been proved to their satisfaction.

5 Then the third sort of general head related to
6 an allegation there had been various breaches of the
7 Remand Home (Scotland) Rules of 1964. I am not again
8 going to get into the nitty-gritty of this, other than
9 to say that there was an issue raised and was commented
10 upon that there was some doubt whether the 1964 Rules
11 survived the passing of the Social Work (Scotland) Act,
12 and certainly by 1973 the whole system was up and
13 running. What an investigator said, if we can turn to
14 page 18, on the point was that, and it starts about six
15 lines down:

16 'We are at a loss to understand why two years have
17 been allowed to elapse and no new regulations have been
18 made to replace those which have expired, nor has any
19 administrative direction been given by the Secretary of
20 State on the lines that social work establishments
21 should meantime observe the old regulation. In Glasgow
22 the Director of Social Work has informed us that by
23 tacit understanding between him and Mr LRL, SNR
24 SNR at Larchgrove, the old regulations would
25 continue to be applied. We therefore take the view that

1 any failure to observe these regulations is not
2 technically a breach of them, but is rather a failure to
3 comply with implicit instructions.'.
4 So that's the way that they put the matter. It
5 probably doesn't make a lot of difference in substance,
6 because --
7 LADY SMITH: It doesn't make much difference to the children
8 who are on the receiving end of treatment.
9 MR PEOPLES: No, whether it was a breach of an instruction
10 or a breach of a regulation, it is not much comfort to
11 say, 'Well, it is okay, it's not in breach of the
12 regulations'. But that's how it is put. When we do
13 then look to see what they are referring to, we see,
14 starting towards the foot of page 18, the first matter
15 is that corporal punishment in excess of six strokes has
16 been administered and upon the naked posterior, and we
17 have seen findings to that effect, as illustration.
18 Then they say that there was striking, cuffing and
19 shaking that took place. Again we have that, which
20 would be contrary to the rule and contrary to the
21 instruction.
22 There was also no form of occupation was in general
23 provided for a boy in the cell, as required by the rule
24 and the instruction.
25 Moving to page 19, I think we are now, the

1 separation by cell confinement quite often lasted from
2 Saturday morning until Monday morning, which was for
3 more than the 24 hours provided by the 1964 rules that
4 have been referred to.
5 Then, finally, it says:
6 'Separation by self confinement was not always
7 recorded in the logbook.'
8 So we have a situation there where they have found
9 that not everything that should have been recorded was
10 recorded, and I think we have seen examples of where
11 what was recorded was not accepted as an accurate record
12 of what happened.
13 A. Yes.
14 Q. At this point they prepare the ground for part 2 by
15 saying:
16 'Specific and general allegations of misconduct by
17 staff at Larchgrove cannot be fairly looked at in
18 isolation from the surrounding circumstances in which
19 the staff were placed. While violence, even of a minor
20 degree, cannot be condoned, it must be understood in its
21 context. The blame cannot, in our opinion, be wholly
22 put upon the staff concerned.'
23 I think that is when they then turn to the more
24 general issue in part 2 of responsibility for the state
25 of affairs that they found at Larchgrove.

1 If we can look at that now, it begins, and I think
2 we can read it, I will just try and see if we can take
3 this short, but it begins, part 2, with a section on the
4 function of assessment centres, because this was
5 an assessment centre.
6 A. Yes.
7 Q. And the importance of assessment, I think that's also
8 something that is stressed at the outset of part 2.
9 A. Mm-hm.
10 Q. The purpose was to help children's panels, the new
11 children's panels system, and the courts to make
12 appropriate decisions in relation to children appearing
13 before them, whether as offenders or children in need of
14 care and protection. This is being said at page,
15 I think, 22 of the report.
16 It also makes the point that it is really the
17 responsibility of the social work department for putting
18 in place an assessment service that is fit for purpose.
19 That's the essence, I think, of the point being made at
20 that part of part 2.
21 If we move to pages 23 and 24, the point is made,
22 I think, towards the end of 23 and over to 24, that care
23 staff who form part of the assessment team must be
24 appropriately qualified and trained for the task they
25 are required to perform. It also says, and this is

1 perhaps again something that maybe has shades of what
2 happens later at Kerelaw, that the staff must receive
3 professional support from their manager. So there is
4 a theme there which I think we see in the later report
5 picked up as well, and this is support both within the
6 assessment centre itself and from external managers with
7 responsibility for the centre. So you can see there is
8 a similarity to that extent between what was found to be
9 a problem at Kerelaw and what was earlier found to be
10 a problem at Larchgrove in terms of support --
11 A. Mm-hm.
12 Q. -- and internal and external management.
13 On page 24 it was pointed out, I think, in essence
14 that if assessment of a child's behaviour in a centre is
15 to be of any assistance to panels and court, it should
16 be based on observation of conduct that represents, as
17 far as possible, the child's real self and not a set of
18 rigid automatic responses to military style rules
19 designed to damp down expressions of genuine feeling.
20 I don't suppose you would quarrel with that statement in
21 today 's world?
22 A. No, not at all. I think it does speak to -- in reading
23 the report, it's as if they hadn't actually made the
24 shift at all from being a remand centre, again the use
25 of language I think belies that, in that they hadn't

1 actually moved to undertake an assessment function. And
2 it is interesting that some of the reasoning for that
3 appears to be that, you know, there weren't regulations,
4 or --
5 Q. I think you would agree, would you not, that the lack of
6 appropriate regulations at the time doesn't explain or
7 excuse this, does it?
8 A. No, it absolutely doesn't, no.
9 Q. Regulations don't, in themselves, bring about change?
10 A. No.
11 Q. There have to be other actions that will achieve that?
12 A. But also to have operated for two years without --
13 because you would have had a responsibility as the
14 provider of the service to raise those issues, to put
15 something in its place.
16 Q. Well, I think as we will see, I think that to some
17 extent -- well, to a large extent the independent
18 investigation do blame the Corporation, not just the
19 staff.
20 A. Yes.
21 Q. I think they were clear on that point. In due course we
22 will perhaps come to that.
23 A. Yes.
24 Q. At this stage they are really setting out what has to be
25 done, or what should have been done.

1 On page 25, at the top, it is summarised, really:
2 'In short, skilled nurturing care is as essential in
3 short-stay assessment centres as it is in long-stay
4 children's homes.'.
5 I mean they are certainly introducing the concept of
6 nurturing, as well as care --
7 A. Mm-hm.
8 Q. -- but it is clearly saying that this isn't something
9 that seems to have been present, at least in Larchgrove,
10 at that time?
11 A. Yes.
12 Q. They then move on to look at the situation at Larchgrove
13 against that introduction. The first matter they
14 address is what's described as 'defects in the regime'
15 and that starts on page 25.
16 First of all, I think that the inquiry really
17 characterised the regime as a control system.
18 A. Mm-hm.
19 Q. What they did was to identify a number of features of
20 the regime as ones that went some way to explaining the
21 climate of potential violence in the centre and how it
22 came about that staff were too often under pressure to
23 use more than minimum force in their approach to the
24 boys. I think that's something that runs through this
25 section of the report.

1 A. Mm-hm.
2 Q. The other point that perhaps comes out is that
3 a disproportionate amount of time and attention was
4 given to control and discipline at the expense of the
5 primary task of assessment.
6 A. Yes.
7 Q. Which is perhaps harking back to the good old days of
8 Approved Schools and List D schools, where perhaps that
9 was the prevailing approach --
10 A. Mm-hm.
11 Q. -- in many places. I mean I appreciate you will not be
12 able to tell us from personal knowledge, but I think you
13 will be well aware, probably, from what you perhaps
14 learned, including from what people who have come to
15 this Inquiry have told the Inquiry?
16 A. Yes, it was both explicit in terms of a function and
17 implicit then in terms of -- I think in particular,
18 a sense of keeping control of, and there to be no, there
19 to be no kind of articulation of behaviour or feelings.
20 I think that is said earlier on in this report and
21 I think that's a really good description of it. It is
22 almost as if the function was to dampen down any sense
23 of feeling or emotion from the boys.
24 Q. Could it be put this way: really the boys weren't
25 treated as individuals, but as a group primarily to be

1 controlled --
2 A. Yes.
3 Q. -- by a single regime --
4 A. Yes.
5 Q. -- in one way?
6 A. Yes, quiet and controlled.
7 Q. If we look at the features that caused them to be
8 disturbed, and which they believed tended to foster
9 rather than reduce the atmosphere of potential violence,
10 they do look at these, I think, between pages 25 and the
11 pages following.
12 They say, I think at, is it, if we pick it up, for
13 example, at page 28, but I think that they say something
14 to the effect that much time and energy and work is
15 devoted to custodial control of boys' behaviour within
16 the centre and prevention of boys from absconding.
17 And the system itself -- this is a point that they
18 make -- severely restricts freedom with which boys may
19 express their real feelings, so that the behaviour
20 accessible to staff is unrepresentative in some
21 instances and perhaps misleading if it is to form the
22 basis of a report --
23 A. Yes.
24 Q. -- to the court or the Panel?
25 A. Yes.

1 Q. So it is not exactly helping?
2 A. No, and it is curious, because I know part of the
3 challenge in terms of the Inquiry is trying to think
4 about context. So this is with some degree of
5 hindsight, but also from a professional perspective,
6 those views about the kind of regimes that are more
7 likely to incite violence rather than to manage it would
8 have been known at the time. They weren't outrageous
9 theories in terms of psychological theory, for example,
10 and in terms of managing people who have had trauma in
11 their childhood, they are not new.
12 Q. No, I appreciate what you are saying, but can I make
13 this point: they may not have been new and they may have
14 been known to those who had that level of understanding,
15 but did the staff have that understanding? It seems
16 not, because they were untrained, they were unqualified
17 and perhaps they simply applied their own --
18 A. Yes.
19 Q. -- attitudes and values and experiences and thought that
20 the best way to control violence is to use violence?
21 A. Yes.
22 Q. Would that be a fair comment? I appreciate what you are
23 saying about there was the understanding around --
24 A. Yes.
25 Q. -- but did the staff have that understanding, without

1 training and experience, supervision, and all of these
2 things?
3 A. It is highly likely not, although you would assume that
4 Mr Carrigan had some of that understanding, and that
5 perhaps that's what motivated him.
6 Q. Maybe he did, but some of the people he would be -- he
7 was only employed there, I think, had only been employed
8 there for about two years prior to whistleblowing.
9 Whereas I suspect -- well, for example SNR
10 SNR, as I understand, was there from 1955, as
11 SNR --
12 A. Yes.
13 Q. -- and SNR had been there as SNR certainly
14 from the 1960s, so we are talking about what I described
15 this morning as the 'old guard' and they would not
16 necessarily have entered the system at a time when
17 either the understanding existed or subsequently, if it
18 developed --
19 A. Yes.
20 Q. -- that they would have had the training to take that on
21 board and apply it.
22 A. Yes.
23 Q. I am just trying to get at it, but we have a situation
24 where there are probably a lot of long-serving employees
25 who do it their way, that is the appearance of it.

1 A. It is the appearance of it, and I think that kind of
2 link to its previous function as well, it is just being
3 perpetuated. I suppose it talks to the shift from
4 remand to assessment.
5 Q. I suppose the fact that they are able to say that the
6 great majority of supervisors, this is at page 29,
7 I think, perceived themselves as custodians, primarily,
8 whose job was to maintain order and prevent breaches of
9 discipline maybe tells its own story?
10 A. Yes, yes.
11 Q. That's their perception of their job?
12 A. Yes.
13 Q. On pages 30 and following I think the inquiry team seek
14 to consider the effects of the daily routine at
15 Larchgrove at that time, and I think the routine itself
16 was described as one of, and I quote, 'unvarying
17 monotony' and one involving pointless ritualistic
18 procedures, such as standing in line.
19 A. Yes.
20 Q. I think they queried what the value of that was, in
21 an assessment centre certainly, even at that time.
22 I think they say:
23 'The total effect in practice, if not in intention,
24 is drab, repressive, and undermining of individual
25 dignity. It stems from a period when it was thought

1 appropriate that remand homes should be primarily places
2 of detention and punishment. It is unsuited to the
3 concept of assessment.'
4 So it is pretty clear what's thought there?
5 A. Yes.
6 Q. That is probably being expressed by someone who at the
7 time was a child care expert, Mr Righton --
8 A. Yes.
9 Q. -- I don't think that came from Sheriff Bennett, to be
10 perfectly honest. That is presumably why Mr Righton was
11 chosen at the time --
12 A. Yes.
13 Q. -- he did have some understanding of modern practice and
14 the purposes of assessment.
15 If we carry on just through that section, I think we
16 see around, starting around page 32 and following, that
17 it is really saying that the regime as a whole involved
18 a lack of adequate stimulation, which I think in modern
19 times is seen as something that might provoke --
20 A. Yes.
21 Q. -- behaviours --
22 A. Yes.
23 Q. -- that otherwise could be avoided?
24 A. Yes.
25 Q. If you have people with nothing to do and are bored in

1 a closed setting?
2 A. Mm-hm.
3 Q. I think they make the point, and I think this is towards
4 page 34, that there was no qualified teacher in the
5 classrooms. I think Mr LRL did have a teaching
6 qualification but he didn't descend to the classroom.
7 So what they are saying there in essence is that this
8 was an assessment centre which was making use of
9 unqualified staff --
10 A. Mm-hm.
11 Q. -- who didn't really have a clue what was involved.
12 Again, the issue of unqualified staff is a theme
13 that we have come across in many case studies in
14 a context in which we are dealing with vulnerable
15 children with complex and varied needs.
16 A. Mm-hm.
17 Q. That seems to mean -- it is not confined to Larchgrove.
18 It seems that the vast majority of care staff for many
19 decades of the period we are looking at were largely
20 unqualified, inexperienced, poorly supervised and so
21 forth?
22 A. Yes, that's my understanding, and particularly in the
23 residential setting --
24 Q. Yes.
25 A. -- and also that it talks to my earlier point that

1 although in kind of professional social work the concept
2 and theories were around at the time, they didn't
3 translate into residential child care, you know, or they
4 didn't seem to translate into residential child care.
5 Q. I think at pages 34 or 35, there is also the point made
6 that the regime that was being described made it, as it
7 was put in the report, virtually certain that staff-boy
8 relationships were, as described, impersonal and
9 distant.
10 I take it that the modern approach is to foster good
11 relationships, not to have a them and us approach?
12 A. Absolutely. And actually The Promise, which is probably
13 the most current policy framework for us to operate in
14 now, talks about love.
15 Q. Yes. I think that's a more difficult concept to apply
16 to residential care, but you are quite right in saying
17 it does say that. But I am looking more at the more
18 broad issue of relationships between a professional and
19 a young person in a residential care setting.
20 A. Yes.
21 Q. I don't want to get it narrowed to love --
22 LADY SMITH: Just before you leave that concept, sorry,
23 Susanne, I can't remember whether I raised this with you
24 before, it is not realistic, is it, to ask somebody to
25 love every child towards whom they have responsibilities

1 because of the work that they are in, whereas it is
2 reasonable to expect them to do their best to take good
3 care of the child, and that's not the same thing.
4 A. I think The Promise has given us real challenges as
5 a profession. I have probably changed my view over the
6 years, and was initially very challenged by that
7 concept. What's been interesting to me in the last
8 few years is talking to young people, and young people
9 that we have looked after, our children who have gone
10 through, who have gone through and participated in The
11 Promise participation work that goes on.
12 I am quite struck by, more than I thought, of the
13 young people expressing a view that that's what they are
14 looking for from the state.
15 LADY SMITH: I can understand that. I am looking at it from
16 the point of view of the person who is working with the
17 children --
18 A. Yes.
19 LADY SMITH: -- and how realistic it is to say to somebody
20 that as part of your work you must love somebody else's
21 child.
22 A. Yes.
23 LADY SMITH: When they can do every aspect of the job really
24 probably quite well, but may well say, 'Come on, don't
25 ask me to love the child, that's not what it's all

1 about, after all. I can do the job really well and make
2 them feel cared for and important, but not love them'.
3 A. So I think -- I genuinely do think that is the challenge
4 for us, in providing care for young people who can't be
5 accommodated in their own families.
6 MR PEOPLES: Is it not maybe that -- well, it might be
7 described as they want love, they want a certain degree
8 of affection, sometimes they want a hug, whereas no
9 doubt there was a time when there was a fear that that
10 would be misinterpreted. But they might want something
11 they would get in a family home. They wouldn't just get
12 discipline, rules, and told how to grow up a responsible
13 citizen. They would get something that was a bit more
14 than that. Whether they would then translate that into
15 what you would call a true loving relationship between
16 a parent and a child may be a different question, but it
17 is clear enough, probably, what they want. They don't
18 just want to be sort of, 'I never have any kind of
19 physical contact with an adult that in some way shows
20 that they care for me in a certain way', not in
21 an inappropriate way, but something that is lacking,
22 that they are not getting that.
23 I mean it may be difficult to put/define it exactly,
24 but use of the word 'love' can perhaps, might be the
25 wrong way of expressing what they want.

1 A. It is not what young people tell us, I mean, but --
2 Q. They use the term 'love' do they?
3 A. Yes, they do. And it is really challenging. It is by
4 way of illustration in terms of the kind of the
5 significant shift in relation to contacts, and young
6 people do tell us that they want to feel that they are
7 loved and that they are valued and that they belong.
8 Q. I don't mind the last two -- sorry, feel they belong and
9 valued, but are they saying that they want the love that
10 their, for example, biological parent would give, say,
11 if they, let's not assume that they have had such
12 a relationship that they would not want to have any
13 contact with them, but are they wanting a different form
14 of love as they call it, or is it, are they wanting them
15 to be effectively the substitute parent as well as the
16 primary carer? Is that what you are getting told?
17 A. For some young people, and for others, again, it is more
18 complicated, because they are looking for that from us
19 as well as maintaining a relationship with their
20 families, which can be difficult for them.
21 I mention it, as I say, by way of trying to
22 illustrate how far that the expectation of residential
23 child care staff has shifted. And it is a real
24 challenge to the profession, but the voice of young
25 people has been really clear on The Promise. I don't

1 think that we have resolved it in terms of where you
2 land, but that is what young people are telling us.
3 Q. Well, can I put it this way, then -- maybe we can go
4 back to the report in 1973 to see what it says about
5 this impersonal, distant relationship because of the
6 nature of the regime. I think it is at page 35. It is
7 what is described as a paradox, and it says:
8 'The regime [about halfway down] blocks almost all
9 real emotional contact between individual supervisors
10 and boys, yet each side develops strong and often
11 hostile feelings about the other.'
12 Emotional contact might be an attempt to capture
13 something that's maybe short of what you would say was
14 the love between a parent and a child in a healthy
15 relationship --
16 A. Mm-hm.
17 Q. -- but you can see where they are coming from?
18 A. Yes, yes.
19 Q. That they are not getting any kind of feeling that they
20 are wanted, they are cared for, they are valued, they
21 are respected, and they are guided, and all the things
22 that perhaps are in a community between a healthy
23 relationship between parent and child they might expect
24 to receive.
25 A. And in my experience residential child care, but also

1 social work, requires emotional commitment as well as
2 the whole set of skills and experience and knowledge
3 that you apply, but it does require emotional commitment
4 and it requires emotional commitment in the relationship
5 with the person that you are looking after.
6 Q. Angus Skinner said to us a long time ago that one of the
7 problems he saw was that also when people look at their
8 records everything seems very negative. They always
9 write down the negatives, and they do not have much to
10 cling on to by saying, 'Well, my childhood had positives
11 and they recognised it and they also pushed the
12 positives and didn't simply emphasise the negatives'.
13 A. Yes.
14 Q. Perhaps that, to some extent, is also what they are
15 looking for?
16 A. Yes.
17 Q. Some recognition that they have a value and a worth,
18 whatever the situation.
19 A. Yes. That has to be conscious -- so we are, we have
20 trained our residential child staff on asset-based
21 recording, specifically for that reason about how they
22 record, because it is so important.
23 And, to be fair, part of that stock take for us was
24 the Inquiry, in terms of some of the feedback from
25 witnesses, and how important. And I think the last time

1 I said that, my Lady, about I have a strong view that
2 recording is a core element of our professional
3 practice, it is not a by product, it is not an admin
4 function, but to be done well. And you can do it well.
5 But we need support staff to be able to do that, you
6 wouldn't necessarily just expect people to be able to do
7 that.
8 Q. Perhaps I can read on then, just on the basis of what
9 you have been saying and we have been discussing. On
10 page 35, after the paradox is identified, it says:
11 'There are two possible consequences. Either
12 feelings become frozen because they are felt to be too
13 dangerous: eg boys retreat into time compliance, and
14 supervisors into safe custodial roles. Or feelings
15 spill over, but, because they are denied direct outlets,
16 take devious routes. For example, supervisors may
17 express their [I am not quite sure where they are going]
18 express their thwarted love by making a pet of one boy
19 and their thwarted hate by making a scapegoat of
20 another. Boys prevented by their code of toughness from
21 expressing even thwarted love, at least to supervisors,
22 concentrate on venting hostile feelings through defiance
23 and disruptiveness.'
24 I don't know whether you can help us with what he is
25 driving at there?

1 LADY SMITH: This is probably Righton that has written this,
2 isn't it?
3 MR PEOPLES: Oh yes, I think. It is not Sheriff Bennett,
4 I think we can take it.
5 LADY SMITH: Sheriff Bennett did, if I recall rightly, have
6 quite a large family himself --
7 MR PEOPLES: Yes.
8 LADY SMITH: -- but his part of the report does read as the
9 Sheriff lawyer's analysis.
10 MR PEOPLES: We agree it is a joint report, but I think this
11 is the language of someone who is the social work
12 expert, but what do you think is being said there?
13 A. What I think is being said there is because there wasn't
14 an honesty, an openness, and an emotional commitment in
15 the relationships, in the care that was offered to the
16 boys, is that their expression of any of their emotions
17 was dysregulated and expressed itself in hostility,
18 because that's how they protected themselves.
19 Q. There is another angle to it, because I think we have
20 heard in evidence that boys particularly will feel that
21 any expression of emotional feeling towards a situation
22 will be detrimental to their survival in a --
23 A. Yes.
24 Q. -- group situation.
25 A. Mm-hm.

1 Q. So that they try to suppress it or hide it, however they
2 are feeling, whether they are feeling depressed, or
3 whatever.
4 A. Mm-hm.
5 Q. I think we have seen that?
6 A. Yes.
7 Q. So there is that complication as well?
8 A. Yes.
9 Q. That they don't necessarily feel confident that even if
10 they were to express something to an adult, that if it
11 got back to the their mates it would be something that
12 they would either understand or not take advantage of in
13 the wrong way?
14 A. Yes.
15 Q. That may be still true today?
16 A. I think there is evidence that that's true today. There
17 are still gendered expectations of behaviour and
18 expressions of emotion. I think there is clear evidence
19 of that.
20 Q. Yes, how much of yourself you are prepared to give away
21 in a certain context.
22 A. Mm-hm.
23 Q. Not just to adults, but to those around you who are your
24 peers?
25 A. And the more unsafe you feel, the less likely you are to

1 behave like that.

2 Q. Yes. And just to round off this part of the report, and

3 the features of the regime, I think it finishes off, on

4 page 36, as saying that the regime is being described as

5 'an impersonal and emotionally bleak regime', which is

6 a rather depressing conclusion, is it not?

7 A. Yes. But there was evidence for that in the report.

8 Q. Oh, yes, I know. The comment about being depressing is

9 not that the evidence didn't exist, because clearly it

10 did.

11 We are talking about 1973 here, it is not the dark

12 ages?

13 A. Yes.

14 Q. However, it doesn't stop there and the inquiry goes on

15 to say that the regime itself alone cannot wholly

16 account for the situation at Larchgrove. This is

17 discussed under this heading starting at page 36, with

18 'Other contributory factors'. We then see a number of

19 factors which are identified that are contributing to

20 the state of affairs at Larchgrove, one of which is, if

21 we see on pages 37 and 38, is overcrowding.

22 A. Mm-hm.

23 Q. Which was a persistent problem at Larchgrove and indeed

24 I think other places, as we know?

25 A. Yes.

1 Q. The point is also made at page 38 in relation to this
2 factor of overcrowding, that in practice all boys,
3 whatever the nature of their problems, are subjected to
4 the same regime.
5 A. Mm-hm.
6 Q. So if you have a large institution, a large number of
7 boys, perhaps too many, they all get treated the same
8 way, and there is not much chance for giving them
9 individual attention to meet particular needs?
10 A. Yes, and I think that's particularly pertinent, because
11 it was supposed to be an assessment centre, and it was
12 precisely that which it was supposed to do, was to
13 assess those individual needs.
14 Q. Another point that's seen as a contributory factor to
15 the state of affairs is that the staff are overworked?
16 A. Mm-hm.
17 Q. They are under pressure, overworked, no doubt partly due
18 to the numbers but no doubt to other factors too and it
19 says they have inadequate time for proper rest and
20 relaxation, let alone for thinking and study related to
21 their jobs. So they don't have time to reflect or
22 understand and think through their practice, and so
23 forth.
24 A. Mm-hm.
25 Q. Then of course another factor that's mentioned, starting

1 on page 38, are the facilities themselves, the
2 buildings, which may well have been well designed for
3 their original purpose of control and custody, but are
4 quite unsuited to modern conceptions of care and
5 assessment, and also making sure that people have
6 individual privacy and freedom of movement. So that was
7 another factor at Larchgrove?
8 A. Yes.
9 Q. Does that explain to some extent why your houses have
10 been refurbished in more recent times?
11 A. Yes, I think we are really clear about the impact of the
12 physical environment, and our children's houses are
13 houses, they all have en suite bathrooms as well as
14 different facilities for coming together, big kitchens,
15 a family room, and a room that they can take their own
16 family when they come, as well as a study room.
17 Q. If you are trying to have some form of group living,
18 albeit it can't completely replicate a family home,
19 I think Angus Skinner said, again to go back to him,
20 about if you had to ask for an apple for permission, you
21 couldn't just pick something from a bowl, because there
22 was a rule that you ate and you sat and ate what you
23 were served and you didn't have the freedom just to have
24 something without, maybe, someone coming down on you for
25 breaching the house rules?

1 A. Yes.

2 Q. That's surely quite ridiculous when you see it now?

3 A. Yes, and I think it is something that, again, you have,

4 but you have to stay alert to. So there is some really

5 interesting discussions, for example, we have with

6 health and safety, because you have to have certain

7 notices, because you are running a children's house, but

8 also you can be quite inventive, because you can have

9 those words, but they don't have to look like the

10 form -- as long as you have got them, so I found out as

11 long as you have the words up in relation to health and

12 safety and exits and things like that, but it doesn't

13 have to be formal like you would get in an institution,

14 or an ordinary building.

15 So there are all sorts of -- you have to be quite

16 inventive about, and notice where ... so the use of the

17 office is another one for us. That we have to be

18 really, have a particular focus on and work with staff

19 not to retreat to an office. We do need a room in each

20 of the children's houses where the computers are kept,

21 where staff are able to have, you know, phone social

22 workers, for example, but not to retreat into there.

23 Most of your time working in a children's house should

24 be spent in the house with the children.

25 Q. I get that, and I suppose in an ordinary home you don't

1 see 'fire exit' even if there is a fire door --

2 A. Yes.

3 Q. -- I mean you have to use a modicum of common sense

4 here, don't you --

5 A. Yes.

6 Q. -- to create what you say is the best equivalent you can

7 to a family home?

8 A. Yes.

9 Q. You don't basically want to make it a mini institution?

10 A. Yes, but you do need a fire certificate.

11 Q. I follow what you are saying, that the law requires it,

12 but there may be ways --

13 A. There are, there are.

14 Q. -- to try to find a better way to do that, or to comply?

15 A. Yes.

16 Q. And if there aren't, maybe people should be thinking

17 about, even those that issue the certificates, without

18 compromising safety?

19 A. Yes, and those are some of the discussions we have had

20 to have when building our units with some of the other

21 external agencies who don't necessarily have that

22 background. Something like that's really important, you

23 know, asking for a second exit, we had to work really

24 hard with the fire service.

25 Q. A point that's maybe coming out of this exchange is that

1 while it may not seem important, there are small things
2 that make a huge difference --
3 A. Yes, yes.
4 Q. -- to the perception of the place and to the feelings of
5 the young person towards the place?
6 A. Yes, absolutely.
7 Q. And if you don't take care of the small things then you
8 might have a problem?
9 A. Yes, absolutely, mm-hm.
10 Q. Then the next factor that's mentioned in the report at
11 page 39 was the lack of feminine influence, and I think
12 it is fair to say that, apart from some of the domestic
13 staff and the matron, there wasn't much of a presence of
14 women at Larchgrove in the early 1970s, I think it was
15 largely male dominated. I think that is a difference
16 from Kerelaw --
17 A. Yes.
18 Q. -- although not necessarily a difference with
19 a difference, because I think at Kerelaw the conclusion
20 was that there was a macho culture, notwithstanding that
21 there was a reasonable percentage of women?
22 A. Mm-hm.
23 Q. So notwithstanding that Kerelaw had more women --
24 A. Yes.
25 Q. -- what was described as a macho culture still

1 pervaded --
2 A. Mm-hm.
3 Q. -- the institution.
4 A. Yes it did. There were more women. It was also located
5 in a community where that was the prevailing culture.
6 Q. Yes. And I think they try to burst the myth that in
7 some way to control young boys who may have had
8 a challenging background --
9 A. Yes.
10 Q. -- and have been aggressive in other placements, you
11 need to get some tough males with physical attributes to
12 keep them in check.
13 A. Yes.
14 Q. I think certainly the profile of some of the recruits
15 for Kerelaw seem to fit that description, that they were
16 not necessarily from any child care background and they
17 were often chosen for their physical prowess, as much as
18 any other strengths?
19 A. Yes.
20 Q. Yes? That's not me saying something that's coming as
21 news to you, is it?
22 A. No, that was one of the findings, both in terms of the
23 internal inquiry and the independent inquiry.
24 Q. Yes.
25 A. And it goes back, I think, to that, it goes back again

1 to whether you -- working in residential child care was
2 seen as a job or a vocation, and I think it was a job.
3 Q. The process of recruitment was quite rudimentary?
4 A. Yes, it was.
5 Q. People could just come in from having worked in other,
6 maybe even heavy industries in the Ayrshire area, and
7 then change direction and work as a sessional worker, I
8 think then, and then sometimes became full time.
9 A. Yes.
10 Q. And they became the managers?
11 A. Yes, and also the connection.
12 Q. And the connection --
13 A. The connection between people being recommended by
14 people that were already in Kerelaw, so there was
15 a significant amount of familial and community
16 connection then in the people that was being refuted.
17 Q. I think it was sometimes described as cliques and
18 factions --
19 A. Yes.
20 Q. -- and that didn't make for some form of united staff or
21 united approach, and also wariness between staff as to
22 what they could say and to whom, that this was all
23 prevalent.
24 A. Yes.
25 Q. I think we will hear more about that from our witness

1 tomorrow, that was the gist of it wasn't it?
2 A. Yes.
3 LADY SMITH: On recruitment of course we saw something along
4 the lines of what you have been describing, Mr Peoples,
5 in the Scottish prison chapter before Christmas.
6 MR PEOPLES: Yes.
7 LADY SMITH: Quite prevalent there.
8 MR PEOPLES: It has addressed, and no doubt Glasgow City
9 Council will say they have addressed the question of the
10 predominance of males and perhaps in senior management
11 positions, for example. I think your current Chief
12 Executive is female.
13 A. Yes, I think the last local government benchmarking
14 report actually was one of the benchmarks where Glasgow
15 City Council scored, if not among the top quintile in
16 terms of the gender balance in relation to senior
17 management.
18 Q. Then another factor is said to have been the inadequate
19 training opportunities and consultancy services for
20 staff. Now, that's really rolling two things together.
21 A. Mm-hm.
22 Q. I think that's probably rolling out that they are not
23 really getting sufficient training for the job they are
24 doing, and also they are not really getting the type of
25 supervision that's required in terms of appraisal,

1 guidance, performance management, and so forth, is
2 that --
3 A. Yes.
4 Q. Do you think that's really what they are driving at
5 here?
6 A. Yes, I think also -- so I think it's supervision and
7 it's training, but also other experts, because if you
8 think about the range of issues that the boys would have
9 had, you could reasonably expect that they would have
10 had access to other experts in terms of an assessment.
11 Q. But they don't seem to have done any of this --
12 A. No, they don't.
13 Q. -- they don't even seem to have had the normal, or the
14 methods that you described this morning of a formal
15 supervision, performance management system, appraisals,
16 and the like --
17 A. Yes.
18 Q. -- on a regular basis?
19 A. Yes.
20 Q. Indeed, they make quite a serious criticism at page 40,
21 at the top, it says:
22 'The overwhelming majority of supervisors are
23 untrained in residential work at any level. It seems to
24 us improper [so it is quite strong language] to expect
25 staff to do one of the most difficult and demanding jobs

1 our society has to offer without at least a minimum of
2 training and preparation. Yet, there seems to be no
3 social work department in-service training scheme
4 sufficiently well developed to include more than
5 a handful of untrained staff.'.
6 Then they say, as they develop the point towards the
7 end of the paragraph:
8 'This seems to us the equivalent of being thrown in
9 at the deep end.'
10 Well, I think that's a justified comment, is it not?
11 A. Yes, it is, from their description.
12 The one thing I did wonder when I read it was they
13 don't make any reference, again, to context. I am not
14 sure how many places would have been, you know, actively
15 training their resident staff at that point in time, it
16 was the 1970s.
17 Q. I think there was plenty of times that people said care
18 staff should be trained. I agree with you that I think
19 the opportunities were perhaps a lot less than they are
20 today, but I think it wasn't as if someone invented the
21 wheel or something, it was -- even from the 1940s,
22 I think people were talking about the need for
23 appropriately skilled and trained staff in care
24 settings --
25 A. Yes.

1 Q. -- social care settings.
2 A. Yes.
3 Q. So it is not some new development?
4 A. It is not some new development in terms of
5 recommendations, but it was some time before there were
6 recognised residential child care training courses.
7 I think that's one of the reasons why you do see it.
8 You are right, you see it featured in a number of
9 inquiry reports into residential child care that people
10 are untrained and come from a variety of backgrounds.
11 Q. Langside had a training course in the 1960s, 1962 if
12 I remember the evidence we have had. So I mean it is
13 not as if there was nothing, but maybe it wasn't as well
14 developed as it ought to have been?
15 A. Yes.
16 Q. Maybe if it had been taken more seriously by the
17 providers, who were requiring their staff to have
18 qualifications, that might have also stimulated the
19 growth of training --
20 A. Yes.
21 Q. -- courses and colleges --
22 A. Yes.
23 Q. -- and so forth?
24 A. Yes.
25 Q. Would it not?

1 A. Yes.

2 Q. If there is a demand --

3 A. Yes.

4 Q. -- someone will step into meet that demand?

5 A. Yes, and you can see that, that was clearly evidenced
6 when SSSC moved to make their workforce registered.

7 Q. Indeed, I think it says at 5396 that, just halfway down,
8 in the second paragraph:

9 'There are no arrangements either internally or
10 externally for any form of continuing consultation or
11 supervision to be made available to staff at Larchgrove.
12 The proper execution of responsible and skilled tasks
13 depends on all concerned engaging in regular candid
14 reviews of their working objectives, methods and
15 results, in a situation where sympathetic guidance is on
16 offer. Only so can mistaken procedures and errors of
17 judgment and action be put right and staff grow in
18 professional competence.'

19 So it is spelling out the problems?

20 A. Yes.

21 Q. Moving on, it then seeks, I think, starting on page 41,
22 to allocate responsibility for the current situation, as
23 it is said.

24 It begins with an acknowledgement that staff at
25 Larchgrove are asked to deal with many boys whose

1 records before admission show that they are physically
2 powerful, aggressive, truculent, and prone to engage in
3 impulsive acts of violence. We recognise that any
4 establishment which admits such boys must set up an
5 effective system of control, with clear limits to
6 permitted behaviour and enforceable sanctions when these
7 limits are infringed. What we have argued is that the
8 present regime, together with other contributory
9 factors, has brought into being a control and sanctions
10 system so all embracing and rigid that no time or energy
11 is available to pursue more constructive ends. We have
12 argued further that the system itself, paradoxical as it
13 may sound, tends to provoke the very violence and
14 aggressive attitudes it was set up to prevent.'
15 So it is recognising the challenges?
16 A. Yes.
17 Q. But I suppose that just makes it even more important
18 that you have people that are skilled and trained enough
19 to meet those challenges and understand why they are
20 receiving these challenges from the people that they are
21 caring for, it just underlines the importance of --
22 A. Yes.
23 Q. -- if you recognise that, then you don't put someone
24 into battle, as it were, without the appropriate skills
25 and qualifications --

1 A. Mm-hm.
2 Q. -- to do the job, or the task?
3 A. Yes.
4 Q. Even if you are dealing with a difficult cohort, at
5 times.
6 A. Again, that over reliance on control.
7 Q. Yes.
8 A. Boundary setting is always important when you are
9 working with, when you are parenting children. It is
10 a kind of critical aspect that they know and they
11 understand that the adults are reliable and that they
12 will set boundaries, but that's not what's described
13 here.
14 Q. Then if we go on to page 42, we see that there is
15 a section headed 'The responsibility of the
16 Corporation', so that's the governing body, in effect,
17 and it makes the point, I am not going to read it in
18 detail here, but it makes the point that four years
19 before the social work services group had carried out
20 a fairly extensive inspection, and made, I think, 16 or
21 so recommendations. And that basically there had not
22 really been sufficient attempt to address these and
23 implement them by the time of the inquiry.
24 A. Mm-hm.
25 Q. Indeed, effectively the inquiry itself, I think,

1 repeated some of these recommendation at the end of the
2 day.
3 A. Mm-hm.
4 Q. It may say something for the system, or the lack of
5 enforcement powers that the social work services group
6 had, which was remedied by the Care Commission --
7 A. Yes.
8 Q. -- and the Care Inspectorate, but nonetheless it seems
9 to show that there wasn't really any sufficient heed
10 paid to what was being said by these external bodies?
11 A. Yes.
12 Q. To take the appropriate action.
13 I think it is against that background, is it not,
14 that at page 44, having concluded that the Corporation
15 took no steps, despite, I think, follow ups, after 1969
16 to implement any part of the recommendations of the
17 Social Work Services Group until at least, I think,
18 there was some action in October 1972.
19 A. Mm-hm.
20 Q. They had reached the view, about two-thirds of the way
21 down:
22 'In our view therefore the Corporation must accept
23 a major part of the responsibility for the continuance
24 since 1969 of an inappropriate care regime at
25 Larchgrove, as well as for failure to mitigate the

1 stress-producing circumstances in which staff have been
2 continuously working.'
3 That's the conclusion there, and they appear,
4 despite the failings of the staff and the things that
5 some of them were proved to have done, to be saying
6 well, the Corporation itself must accept major
7 responsibility?
8 A. Mm-hm.
9 Q. Indeed, I think they say that the Corporation itself
10 failed to provide sufficient external managerial and
11 other support to enable SNR [redacted] and his staff
12 to properly discharge their functions.
13 There are echoes of that in the Kerelaw inquiry, are
14 there not, that Glasgow City Council and its
15 predecessors may have been guilty of the same failure,
16 do you accept?
17 A. I think I said earlier, I think that one of the
18 differences for me is that ... so there were policies
19 and procedures in place in relation to Kerelaw, and it
20 was a failure of oversight of those within Kerelaw, and
21 then a failure in terms of consequences, or scrutiny,
22 and then consequences. So there are some commonality,
23 but some differences, I think.
24 Q. Well, could I make this point, though, that one thing --
25 there was a joint investigation internally about Kerelaw

1 by the social work department, I think, and is it the
2 education department set up what was called the joint
3 investigation? This was before the independent
4 investigation.
5 A. Yes.
6 Q. And it was quite critical of what was going on --
7 A. Yes.
8 Q. -- at Kerelaw?
9 A. Yes.
10 Q. But what it didn't really do, and what the Frizzell
11 inquiry did, was to also say that it wasn't just
12 a matter of what was going on at Kerelaw and how it was
13 internally managed, there was also the issue of
14 a failure of external management and also a failure in
15 the stewardship by Glasgow City Council in terms of
16 their responsibilities, not dissimilar to some extent to
17 what we have here.
18 That was -- well, we can ask him, but I think that
19 was what that inquiry found?
20 A. The internal inquiry found the same?
21 Q. No, the internal inquiry didn't criticise, heavily, did
22 it, the Council itself?
23 A. The internal inquiry found failure in the external
24 management.
25 Q. But not at council level, the councillors or the

1 governing body, the stewardship?
2 A. No -- well, it didn't have that --
3 Q. Remit?
4 A. No, it didn't have that remit. That was quite specific
5 in terms of the remit of the Frizzell inquiry.
6 Q. Yes, but I am just making the point that if it didn't
7 have the remit, ultimately Frizzell looked at that and
8 was critical of the Council itself in its failure to
9 address a number of issues, not just the failure of
10 those that it gave responsibilities to in terms of
11 management.
12 A. Yes.
13 Q. The Council itself was seen as a governing body and
14 really has to take its share of the responsibility for
15 letting that situation arise, or do you not accept that?
16 A. I am not sure, actually, no.
17 Q. Okay, we can maybe ask the person --
18 A. The Frizzell inquiry absolutely did find that, but the
19 internal inquiry was also clear about the failure of the
20 scrutiny.
21 Q. I am not suggesting that they didn't do three things.
22 They criticised the internal management.
23 A. Yes.
24 Q. They criticised the external management?
25 A. Yes.

1 Q. They did that, the internal, but what they didn't do was
2 go a stage higher and look at the stewardship overall?
3 A. Well, the stewardship is the external management, it is
4 the same thing.
5 Q. No, no, ultimately, as here, there was criticism,
6 perhaps, of external management, the people that the
7 governing body put into senior management positions, but
8 there is still a governing body above that, in the case
9 of Glasgow Council it is Glasgow Council, it is not
10 their senior management team, like the Chief Social Work
11 Officer, or people below that level, or Chief Executive,
12 there is someone, the Council itself is the governing
13 body. It is just like a board of managers might be the
14 governing body for a private institution?
15 A. I am genuinely not quite following.
16 LADY SMITH: I think we need a break.
17 MR PEOPLES: Perhaps, my Lady --
18 LADY SMITH: I usually take a very short break at this stage
19 in the afternoon, is that okay for you, Susanne.
20 A. Of course, yes.
21 LADY SMITH: Let's do that.
22 (3.04 pm)
23 (A short break)
24 (3.16 pm)
25 LADY SMITH: Mr Peoples, are we going to try to unstitch

1 this conundrum easily?
2 MR PEOPLES: No, I don't think I want to pursue it, I mean
3 I think I --
4 LADY SMITH: Can I just ask this: you are talking about the
5 responsibility of a group of people who are councillors,
6 is that right, or were the Council?
7 MR PEOPLES: The equivalent of the Corporation in 1973 is
8 the Council.
9 LADY SMITH: Exactly.
10 MR PEOPLES: I don't want to labour it, because I think they
11 bear ultimate responsibility and it is just a question
12 of what degree of responsibility they should be --
13 LADY SMITH: But below them, depending on how things were
14 organised, for any individual and institution there
15 would be other people at levels of responsibility for
16 direct supervision and implementation.
17 A. Yes, my Lady.
18 LADY SMITH: That is what you were talking about, is it?
19 A. At the point of Kerelaw as well there would have been
20 other regulations in place in terms of registration of
21 residential establishments and registration actually
22 sits with officers.
23 LADY SMITH: Of course. But at the end of the day, the
24 Council, the Corporation, whatever, can never get rid of
25 their responsibility to be satisfied that that --

1 A. Yes.

2 LADY SMITH: -- which ought to be being done is being done?

3 A. Yes, absolutely, my Lady.

4 LADY SMITH: Thank you.

5 Mr Peoples.

6 MR PEOPLES: If I can put it simply, there are a number of

7 leaders, one of whom will be the governing body, another

8 will be the senior management team, below that there

9 will be middle management, then below that there may be

10 internal management of particular places, it is

11 a hierarchical structure --

12 A. Yes.

13 Q. -- but they all have their own responsibilities, as

14 well --

15 A. Yes.

16 Q. -- as ensuring others discharge theirs, and that's all

17 I am trying to say.

18 A. Yes, and I think to be fair that is probably clearer now

19 in current legislation in terms of the different layers

20 and the different levels of responsibility than it might

21 have been in the past.

22 Q. We are looking at the report, and I will just go back to

23 that, and just so that it is not lost sight of, in the

24 report itself, towards the end, there is a section

25 starting on page 47, 'Responsibility of the Larchgrove

1 SNR ', and so it does make clear that the
2 inquiry's view was that SNR himself
3 cannot be wholly exonerated from blame for the situation
4 at Larchgrove, and to put it in a nutshell, they say he
5 failed to provide the required leadership, and they give
6 illustrations or examples of that failure, including
7 establishing regular staff meetings, taking sufficient
8 care to see that supervisors didn't abuse the control
9 system, and so forth.
10 So that was their view, that he also had to bear his
11 share of responsibility.
12 I think it is fair to say, and I don't want to
13 labour this at this stage, I will just deal with it
14 briefly, is that when they were dealing with this they
15 did, I think, express doubts about the person in
16 charge --
17 A. Mm-hm.
18 Q. -- and the process by which that person became the head
19 of an assessment centre, having previously been the head
20 of a remand home.
21 I think the point was that the Director of Social
22 Work had attempted to persuade a committee of
23 councillors that you needed a person with certain
24 qualities to discharge the functions of an assessment
25 centre and that it would have been better if the post of

1 SNR of the assessment centre had been exposed

2 to open competition. Whereas in fact the existing

3 SNR at Larchgrove, Mr LRL, was appointed

4 to be SNR of the assessment centre. The

5 inquiry, at least, concluded that that in their view was

6 a serious error of judgment on the part of the

7 committee --

8 A. Yes.

9 Q. -- and the Corporation?

10 A. Yes.

11 Q. That's really where it is.

12 So that's the report, and just -- I think I said

13 I would probably return to the press coverage, and I can

14 perhaps just turn to that again. If we could go back to

15 the document, we saw in the there had been

16 a piece, and this is in SGV, sorry, bear with me,

17 SGV-000090752, we had been looking at that this morning.

18 I don't want to take this at too much length, but

19 I think the matter was such that if we go to page 209,

20 that following publication of the report SNR

21 SNR and SNR

22 . So that was the first action taken in

23 relation to that.

24 Then, if we go on we see that, I think on page 202,

25 I think, that there was a piece praising the

1 piece on , the date of publication,
2 'The man of courage who came to the ', and as he
3 it, 'Defied his bosses to tell the what really
4 went on at a boys' home'.
5 It is reported that within hours of the report being
6 published, sweeping changes were promised, so there was
7 a commitment to make sweeping changes following the
8 publication of the report.
9 By this stage the Crown were taking an interest in
10 the matter, and indeed had said that initially part 1
11 should not be published, because they were investigating
12 possible criminal offences.
13 At page 203, I will mention this just because it is
14 the Record's view at the time that while the report
15 itself blamed the Corporation and indeed SNR
16 SNR , the 's position seemed to be that
17 on responsibility, if we see it there, that while they
18 weren't doubting that officials of Glasgow Corporation
19 who were responsible for overseeing Larchgrove bore
20 responsibility, and also the councillors, it says, bore
21 responsibility, but the most culpable of all, according
22 to the 's view, was:
23 '... the faceless men of the Scottish Office who had
24 responsibility for issuing the new and humane
25 regulations for homes like Larchgrove and didn't, for

1 two years they have left this task ...'

2 LADY SMITH: Can we just go down a little bit, it's the bold

3 part a little bit further down.

4 MR PEOPLES: '... for two years they have left this task in

5 their in tray, they are really the guilty men.'

6 So the view of at least one prominent newspaper in

7 Scotland was they shouldn't escape censure either,

8 because they should have had regulations in place.

9 A. Mm-hm.

10 Q. I think one can see why that view was expressed, because

11 clearly there was no doubt an anticipation that

12 regulations applying to residential establishments would

13 be introduced --

14 A. Mm-hm.

15 Q. -- relatively quickly, but that didn't happen?

16 A. Yes.

17 Q. In fact it didn't happen until 1987?

18 A. Yes.

19 Q. Residential establishment regulations, which, on the

20 face of it, is a heck of a long time.

21 A. Mm-hm.

22 Q. That was one thing that came up.

23 If we go to page 200, I will just mention this in

24 passing, that this is the Scotsman on the day of

25 publication, 'Remand centre report attacks city'. And

1 it does record, I will just mention what's said, I won't
2 take too long with this, but it says that Larchgrove
3 turned into an assessment centre in 1969, but assessment
4 was regarded by one supervisor as a joke. So one can
5 perhaps start to see why that might have been said.
6 Then if we go to 197 of the same document, this is
7 a piece from the [redacted] on [redacted], so
8 it was getting a lot of coverage, this report, and all
9 I am doing here is it is maybe it is useful to see that
10 we have an aerial layout of Larchgrove, just to show us
11 what it looked like in those days. It just points out
12 the different parts that were there, and described by
13 the [redacted] as, 'Home of shame, a look over the
14 wall'.
15 A. Mm-hm.
16 Q. In light of the published findings. I think in the
17 [redacted] at page 195, and I am not wanting to --
18 I don't think we need spend too much time, but one of
19 the things that's said by SNR [redacted], he is
20 quoted as saying:
21 'Of course there is a lot wrong with Larchgrove,
22 I have known that for years, but I don't agree that
23 I was responsible ...'
24 So he was accepting the problems, but not accepting
25 that he was responsible for causing them --

1 A. Mm-hm.
2 Q. -- but obviously the report concluded otherwise.
3 A. Yes.
4 Q. Then at 194 we see that staff are charged following the
5 report, initially three, but I think ultimately were
6 seven staff charged? I don't want to go through all the
7 newspapers that say that, but there were seven
8 individuals charged, which may have coincided with the
9 number that were found to have committed acts of
10 violence --
11 A. Yes.
12 Q. -- or there or thereabouts, anyway. So that was
13 a consequence, or at least there had been a police
14 investigation, I think, for some time. But charges were
15 not, I think, brought until the report itself was
16 published. I think the investigation started around the
17 time that the story broke in [redacted].
18 A. Mm-hm.
19 Q. Then if we go to pages 186 and 187 of the same document,
20 just to see some more of the cuttings of the time, on
21 [redacted] 1973, this is from the [redacted] of that date,
22 the Larchgrove staff are told at that point that they
23 are not going to be prosecuted and there is a statement
24 issued by the Crown Office at that stage that having
25 made further enquiries the evidence does not justify any

1 criminal proceedings, or doesn't justify criminal
2 proceedings, and it is pointed out that there is
3 a different standard of proof for proof of a criminal
4 offence being beyond a reasonable doubt. It has then
5 cleared the way for the Corporation to take such action
6 as it felt was appropriate in light of the report; do
7 you see that?
8 A. Yes.
9 Q. If I go to page 182, if I just pass to that one as well,
10 this is on [redacted] 1973. The [redacted] has its
11 leading article headed 'Custodians' which gives, it
12 looks like the [redacted] view as opposed to the [redacted] view
13 that we have seen, that disconcerting though the
14 allegations are, they are less alarming than the general
15 background of the incidents. It really raises the point
16 that this was a situation about which the community
17 should be concerned. It says blame for the situation at
18 Larchgrove cannot be heaped entirely on the heads of
19 certain individual staff members, nor is it realistic to
20 say that it is all Glasgow Corporation's fault for
21 failing to oversee Larchgrove properly, although they
22 must shoulder some responsibility on this count.
23 It then says:
24 'We are up against a national shortage of vital
25 facilities and at stake is the whole Children's Panel

1 system set up three years ago'.

2 It appears to be a call for more institutions that

3 are able to cope with the various problems that are

4 pertaining to the juveniles, and it says, really, at

5 present the new children's panels are served by the old

6 and inadequate institutions.

7 That was the --

8 A. Yes.

9 Q. -- feeling at the time. The system had been introduced,

10 but it really didn't have the resources to make it work

11 in the intended manner. And I think that was a view at

12 the time?

13 A. Yes, it was, yes.

14 Q. That not all the requisite resources were in place. For

15 example, panels had very little choice in residential

16 care, they either went for a List D School or some other

17 non-residential alternative?

18 A. Going back to the earlier point about training, not

19 an option about -- so the legislation had been almost

20 imposed upon the old system, as very much changing

21 underneath it, so I think it was articulated by the

22 demands to become an assessment centre and not much

23 evidence that anything other than the name had actually

24 changed.

25 Q. Yes, so there is quite a broad criticism --

1 A. Yes.
2 Q. -- not just in the report but in the media about who is
3 responsible and what has gone wrong, including the
4 absence of regulations, and the absence not just of
5 regulations but of resources to give effect to the ethos
6 of the Children's Panel that you should have a range of
7 facilities --
8 A. Yes.
9 Q. -- that's available to panel members?
10 A. Yes.
11 Q. If we go to page 181, we perhaps see this endorsed by
12 a letter to the [redacted] on [redacted] 1973, which
13 is from John H Godsman, who was the chairman of Greenock
14 and Port Glasgow Children's Panel. I am not going to
15 read the whole letter, we can all read it for ourselves,
16 but it does make the point I have just been discussing,
17 a national problem shortage of vital facilities to make
18 the panel system work.
19 A. Mm-hm.
20 Q. Indeed I think he ends, or towards the end of the letter
21 he ends with quite a strong statement that it is
22 a scandal that the Government should bring into being
23 a system such as the children's hearing without ensuring
24 that there were adequate facilities to carry out their
25 decisions. That's not coming from just any member of

1 the public?

2 A. No.

3 Q. If we go to page 180, however, we also get another

4 response to the [redacted] in this letters page, and

5 this time there is a letter from an individual,

6 Robert Lamont, and essentially it is in defence of SNR

7 SNR if we see, who he describes as:

8 'A man known to me personally, as of the utmost

9 integrity of the highest standing within the community,

10 and of known ability in the practice of his profession.'

11 I think he is trying to defend SNR ,

12 no doubt having read what was said about him in the

13 report.

14 However, what's perhaps also interesting about

15 attitudes is he then turns his attention to the boys

16 sent to Larchgrove and I will maybe just read what he

17 says about them. He describes it says:

18 'The 13-year old who drinks and attempts to rape,

19 the 15-year old would-be gang leader who carries

20 a dangerous weapon and uses it, the boy who deliberately

21 excretes on the bed sheets before rising, the truculent

22 thug who will threaten even the toughest adult because

23 he has some elementary or pseudo-knowledge of the laws

24 governing assault. Go and meet those boys in a group

25 and ask yourself how would you react. That Larchgrove

1 was redesignated as an assessment centre makes no
2 difference to the reality.'
3 Well, it is perhaps a sign of what at least some
4 people, including people who knew SNR [redacted],
5 thought of the Larchgrove population?
6 A. Mm-hm.
7 Q. What do you make of it when you read that?
8 A. Well, I also noticed in the earlier -- one of the
9 earlier cuttings about the prosecutions not going any
10 further, that the chair of the social work committee was
11 grateful that the air had been cleared and they could
12 now get on with things.
13 Q. But when you read that --
14 A. So it is --
15 Q. It is not just Mr Angry, this is someone that is saying,
16 'I know SNR [redacted]' and I don't know who he is,
17 but he is making some strong statements about the
18 population which ...
19 A. It is a view that persists today of the young people
20 that we work with in social work services. And in my
21 opinion, in my view, it stems from a lack of
22 understanding about what young people's experiences and
23 their early experiences and the impact that that has on
24 their behaviour. And it goes back to the point that was
25 made in the report itself about that entrenchment then

1 and a certain kind of behaviours in order to protect
2 yourself, and there isn't anyone that you can trust or
3 work with.
4 We do also work with young people and adults,
5 because we also have responsibilities in public
6 protection, so we do work with young people and adults
7 who present a real risk to the rest of the community,
8 but you can work with people like that with a sense of
9 dignity and with a sense of themselves. But that --
10 those kind of views of the young people that you work
11 with persist today.
12 Q. Yes, so this isn't a 1970s phenomenon?
13 A. No.
14 Q. Okay.
15 A. No.
16 Q. I am not going to take you to the entries, but it would
17 appear that at this point Mr Carrigan of course is still
18 excused from duty, the whistleblower who has been
19 vindicated at least in part?
20 LADY SMITH: We are about two months down the line.
21 MR PEOPLES: We are two months down the line and he is still
22 sitting at home waiting for something to happen.
23 I will just mention the page, we can have a quick
24 look, page 175, just to see how the tale unfolds for
25 him. On the face of it, it doesn't look terribly

1 significant, 'Larchgrove man in pay dispute', but really
2 the issue is that whilst he is excused from duty his
3 average actual earnings have dropped quite
4 significantly, and he feels he should be paid what he
5 normally gets when he is on duty. There seems to be
6 a dispute between him and the Corporation on that
7 matter. And I think the suggestion is that that put
8 some pressure on his family situation, because he was,
9 I think at one point he actually said, I think it is
10 page 173, perhaps, another article on the same point,
11 'The rising cost of courage', if we go to that one, that
12 there was a degree of uncertainty about his future and
13 the price of being a whistleblower seemed to be that his
14 wife had had to go out to work for the first time in
15 several years to make up the shortfall in income.
16 So it is not a great advert for whistleblowers,
17 that.
18 A. No, and it is also not clear -- in the previous article,
19 the difference between excused from duties is not
20 something I would recognise now or then.
21 Q. I don't think it was recognised then. I think in fact
22 the committee that deal with these matters at the time
23 said that there is no such thing as excused, you are on
24 duty our you are suspended from duty. You are not
25 excused --

1 A. No.

2 Q. -- and there is no status of that type.

3 A. No.

4 Q. So they have obviously came up with a formula that took

5 him away from Larchgrove, the people that were accused

6 stayed. He stayed at home and he lost wages?

7 A. Yes.

8 Q. To make, perhaps, matters -- well, perhaps we start with

9 page 171 what happened to the men at Larchgrove who were

10 in fact suspended. It says they were sacked, but that's

11 not in fact accurate. They were transferred to other

12 duties within the Corporation, to jobs within, I think,

13 headquarters, described loosely as administrative duties

14 and I think some staff remained at Larchgrove. I think

15 one was reported as having left since the matter arose.

16 So that's what happened to them. They had different

17 posts following the report.

18 At page 168 there is a [redacted] report,

19 [redacted] 1973, 'New posts for Larchgrove supervisors',

20 which is reporting that Glasgow Corporation accepts most

21 of the blame for the unsatisfactory situation at

22 Larchgrove, and it makes clear there will be no

23 dismissals following the report, although obviously

24 certain action was taken in terms of transfer of staff.

25 Then we still haven't heard about Mr Carrigan, apart

1 from the wage dispute, but if we go to page 164, the
2 [redacted], 'New job offer an insult'.
3 What happens is that he is offered --
4 LADY SMITH: What's the date of this report?
5 MR PEOPLES: [redacted] --
6 LADY SMITH: This is [redacted] still?
7 MR PEOPLES: -- 1973.
8 LADY SMITH: Yes.
9 MR PEOPLES: He is offered the job of a caretaker in
10 a furniture store at a hospital, and I think his
11 reaction, apart from describing it as an insult, was
12 that he felt he was being treated as the villain and
13 being victimised for raising this matter. You perhaps
14 could see some justification for that feeling.
15 A. Yes.
16 Q. Ultimately, however, I think we see, if we go to
17 page 161 briefly, that a few days later it is reported,
18 [redacted] 1973, in the [redacted], that he is offered
19 a different job which is perhaps more in line with
20 a sort of caring role, albeit not with young people,
21 I don't think which he is prepared to accept. But we
22 have also got this heading, 'End of Golden Boy era for
23 man from Larchgrove'. You might think that's
24 journalistic licence, but that's actually what was said
25 by the Director of Social Work at the time, you can see

1 in the third column, I think, a quote from the then
2 Director of Social Work, James Johnson, 'The Golden Boy
3 era has ended'.
4 He tries to explain that, although it doesn't really
5 come out terribly well, it says:
6 'What I mean is perfectly obvious, there have been
7 some organs of the press who have been presenting him
8 systematically as the world's number one benefactor, in
9 fact he is a pretty ordinary guy who did something that
10 whilst some good came out of it, has also made life
11 uncomfortable for other people.'.
12 That's hardly a confident statement if you are
13 trying to encourage people to raise concerns, is it?
14 A. No, I haven't seen any of this before. So, yes, quite
15 extraordinary.
16 Q. He doesn't keep his old job, although he would not have
17 kept it for that long -- no, he would have done, because
18 Larchgrove did stay, unlike Kerelaw.
19 A. Yes, it did.
20 Q. That's what happened to Mr Carrigan. It wouldn't
21 instill other people to follow his lead. There seems to
22 be almost a feeling that he should be criticised for
23 going public?
24 A. Mm-hm.
25 Q. There is an undercurrent like that almost, '... he has

1 made life difficult for a lot of people'. Well, so
2 what, if he has justified concerns and he is not getting
3 them dealt with using the proper channels, if he has
4 raised it and he does not feel he is getting any
5 satisfaction, do you agree that -- we are not in the
6 whistle blowing legislation here, I don't think, at this
7 stage, but --
8 LADY SMITH: And this is the Director of Social Work.
9 MR PEOPLES: Yes.
10 A. But also earlier seemed to be supported by the local
11 councillors, as well, that's what I meant, because the
12 comment was the air's cleared now, there is no
13 prosecution, the other two people stay in employment,
14 and are moved.
15 Q. There is something slightly pejorative about the term
16 'golden boy', isn't there?
17 A. Yes.
18 Q. It carries a connotation, whether intended or not?
19 A. Yes.
20 Q. So that was what happened there.
21 And so even although he has the right at that stage
22 to speak out, he is criticised for doing so. So --
23 A. I think also for the young people, for the young --
24 because some of them did corroborate what happened, and
25 so for them that took some courage, because they saw

1 an adult in Mr Carrigan standing up for them, I imagine,
2 and that didn't -- so this will have impacted on them as
3 well.
4 Q. Yes. So I am going to pass on from Larchgrove.
5 I am conscious of the hour, but I have covered a lot
6 of the comparisons, and no doubt Eddie Frizzell will
7 tell us whether my comparisons are misplaced or not, but
8 I would like just to touch on the Kerelaw report itself,
9 and I think you did say that by that stage you were Head
10 of Children and Families --
11 A. Yes.
12 Q. -- and would have had some responsibility for matters at
13 that time?
14 A. Yes, I came into post and took on responsibility for the
15 implementation of the action plan from the internal
16 review.
17 Q. Yes.
18 A. And also then took on responsibility to be the main
19 point of contact for Scottish Government and independent
20 inquiry for social work services, and then respond
21 thereafter.
22 Q. Can you just, maybe as briefly -- because you have told
23 us about how things have moved on anyway, because
24 I would like to, obviously, come back to you on the
25 restraint issue --

1 A. Yes.
2 Q. -- but can you just tell us briefly the immediate --
3 there was an action plan that had already been --
4 A. Yes.
5 Q. -- formulated before the Frizzell inquiry report because
6 of the internal investigations?
7 A. Yes.
8 Q. That was, I think, to some extent further developed in
9 the light of the Frizzell report?
10 A. Yes.
11 Q. But in essence, what were the main decisions? One
12 clearly was Kerelaw itself had closed --
13 A. Yes.
14 Q. -- in 2006 --
15 A. Yes.
16 Q. -- before Frizzell reported?
17 A. Yes.
18 Q. Beyond that, what would you say was the biggest action
19 taken, practically speaking, in light of that
20 investigation and the Frizzell investigation? Can you
21 help us just very briefly --
22 A. Sure.
23 Q. -- I don't want too much --
24 A. It is difficult to distill it. Beyond the closure, and
25 I wouldn't underestimate -- so the closure did actually

1 meet with some resistance, so it wasn't
2 a straightforward task.
3 So following the closure, so I ultimately had
4 responsibility for that, and the team down there, the
5 main thing was that there are some obvious practical
6 things around about the recruitment, that's one of the
7 things I remember most about the recruitment and
8 completely revamping recruitment into residential
9 services.
10 There was a parallel piece of work that I started
11 then on the modernisation, because that did take
12 a number of years, the modernisation of our residential
13 estate.
14 There was the transformation of children's services,
15 which moved us -- so that was the culture and practice,
16 and I probably couldn't distill that in two minutes, but
17 there was a significant amount of work that goes on to
18 this day in terms of culture and practice. In
19 particular, the practical response was I did
20 a presentation on the outcome of the internal inquiry,
21 which I then took round, personally round, every
22 children and family team in the city. One of the big
23 issues was the visibility and the number of people who
24 were in and out of Kerelaw, including area teams, social
25 workers, psychologists, visiting professionals, who

1 didn't exercise their responsibility and didn't exercise
2 their safeguarding responsibilities.
3 So there was quite a bit of work in disseminating
4 the findings from the inquiry report, and that took
5 a long period of time.
6 Then the safeguarding group board was the group that
7 I set up and chaired for a number of years to develop
8 safeguarding action plans, and to develop that culture
9 and practice around about listening to children. So --
10 Q. Did you beef up external management --
11 A. Yes we did, yes.
12 Q. -- of all residential establishments?
13 A. Of our provided residential establishments, yes.
14 Q. Because obviously it didn't apply to Kerelaw, because it
15 had closed, but --
16 A. Yes.
17 Q. -- there was a criticism of --
18 A. Yes.
19 Q. -- albeit partly because of its location?
20 A. Yes, so there was additional resource put into the
21 external management, but actually it was specifically
22 one of the pieces of work that the independent inquiry
23 undertook, which was really useful, because they spent
24 quite a lot of time on what good external management
25 looked like. So we had already put external resource

1 in, but actually the finding from the independent
2 inquiry really assisted again about the quality, it
3 wasn't just quantity, it wasn't just the resources.
4 So then that was when I developed the work around
5 about supervision, the work around about supervision of
6 the unit managers, the unannounced visits, and the
7 announced visits to the units by the external managers,
8 the safeguarding action plan for each unit, the care
9 plan audit, so the external managers had a very specific
10 remit, which we developed.
11 Q. Can I ask you this then, obviously then you are
12 strengthening the external management systems --
13 A. Yes.
14 Q. -- which was a criticism of the Frizzell inquiry --
15 A. Yes.
16 Q. -- but in terms of recruitment and the importance of it,
17 this is something we touched upon this morning, is this
18 really heralding what we now see when you look at
19 an advert for a post. I was going to use the sessional
20 worker, but it doesn't matter which example I choose,
21 probably in modern times if you have a post advertised,
22 whether it as front line post or a post, there is quite
23 an elaborate system of recruitment in the sense of job
24 description and often quite a lot of information about
25 what's required for the job, not just in terms of the

1 responsibility of the job itself, but the personal
2 qualities required of the person who will get the job,
3 and there is often quite a detailed list of what you are
4 looking for?
5 A. Yes.
6 Q. Is that what we are talking about? Did it move in that
7 direction to get that kind of much more elaborate --
8 A. Yes.
9 Q. -- description of what you are looking for, rather than
10 maybe traditionally 20, 30, 40 years ago a short job
11 advert looking for someone to work in a care position
12 at, for example, a place like Kerelaw?
13 A. Yes, so there are two elements to it in terms of
14 articulating much more clearly what the role of the
15 residential worker was, what the skills were and what
16 the competencies were. So there is a competency
17 framework that we established, but then there is a link
18 between that and the actual assessment and appointment
19 process itself. So we moved to an assessment centre
20 approach, where people would be, where there were
21 exercises where you would be assessing people's
22 competencies that are described in the job description,
23 so it is much more about being able to give evidence
24 that they have the competencies. That's beyond
25 qualification, because again it goes back to the point

1 that qualification doesn't necessarily always give you
2 all of the skills that are required.
3 Q. You are trying to find someone not just who meets the
4 qualifications, but is in fact personally suitable in
5 terms of their values, the qualities that they can
6 display and demonstrate at a recruitment stage --
7 A. Yes.
8 Q. -- in order to try to get someone who is the best fit?
9 A. Yes.
10 So that's precisely what that process moved to. So
11 there is an evidence-based approach to exploring
12 people's value base, their competency base, and also
13 there is an element of it that involves young people.
14 Young people are -- and it also then talks to the value
15 that young people see us placing on the residential
16 staff that then work in their houses. So the young
17 people from the houses are involved.
18 Q. In the recruitment?
19 A. Yes.
20 Q. In terms of feedback?
21 A. Yes.
22 Q. Do they get to see the prospective candidate?
23 A. Yes.
24 Q. All of them or the ones selected?
25 A. The ones selected, yes.

1 Q. They will see them, do they have to give
2 a presentation --
3 A. Yes.
4 Q. -- or deal with a --
5 A. It is usually a discussion, and the young people will be
6 able to ask them questions.
7 That's been an important element of the recruitment,
8 and then you have quite a lot of the, again, the
9 practical, the PVG checks, and all of the other checks
10 that now go on. So it is quite a detailed -- we also do
11 it ... we tend to do it in batches, we wouldn't be
12 advertising one residential job, you know, we are
13 advertising a range of residential jobs and that allows
14 us to take the assessment centre approach, where you
15 have all together --
16 Q. The old days of a short advert asking for a few
17 references from people who may have no understanding of
18 the job and carrying out an interview before a panel and
19 that's about it, is that all gone?
20 A. Yes, yes.
21 Q. There is much more, as I think you described,
22 evidence-based approach to assessing whether people have
23 the requisite qualities, but there is also much more
24 information as part of the recruitment process as to
25 what you are looking for, what qualities they should

1 have, and what the job would involve?
2 A. Yes.
3 Q. But you are testing them against all of these measures
4 before you appoint someone?
5 A. Mm-hm.
6 Q. Is that done by particular people with either
7 a connection with the house or is it done by HR, or?
8 A. It is a combination. So it tends to be operated by our
9 unit managers who are, what we call a team leader grade.
10 Then you would also have team leaders from the locality,
11 so field work social workers involved, but supported by
12 HR so that we ensure we follow due process. At points
13 we had organisation development staff involved, because
14 there is that evidence base around about assessment
15 centres and that's a particular skill that our OD staff
16 bring.
17 Q. If I am a young person who is getting a chance to meet
18 a prospective candidate, and I have expressed the
19 collective view that I am not comfortable with this
20 individual and I articulate that to you, how much weight
21 is given to that, in practice?
22 A. So that's been a challenging one for to us work through,
23 because of the employment legislation around about all
24 of this. That's been quite challenging. Because -- so
25 the employment lawyers tell us that they can't formally

1 have a vote in terms of the appointment.
2 Q. But can they have a voice?
3 A. They can have a voice, they can contribute to the
4 scoring, so we do ask them to contribute to the scoring
5 of candidates at a particular point in the assessment
6 process.
7 Q. I know there are all sorts -- I'm quite familiar, as is
8 the chair, with the requirements of employment law and
9 how difficult it can be, particularly if someone's
10 a disappointed candidate, I think we have all had
11 experience of that, whether they feel the process was
12 fair and it was done in a consistent way. But clearly
13 if you want to hear the voice and you want to hear
14 people who will actually be affected by the choice, then
15 they have to be assured that it is not just going
16 through the motions --
17 A. Yes.
18 Q. -- isn't it?
19 A. Yes, and another experience will be actually you need to
20 spend a bit of time with the young people, so they might
21 say they don't like that person, but actually if you
22 spend a bit of time they are able to articulate what it
23 was, what they heard or what they interpreted. Actually
24 it is quite time intensive, but generally young people
25 will start maybe with a one liner, but if you spend some

1 time with them they can actually articulate what is it
2 they heard, what they were worried about, what they
3 liked, what they didn't like.
4 LADY SMITH: That, Susanne, makes sense, I can see that you
5 couldn't just give significant weight to a view because
6 it came from a young person full stop. But if you had
7 teased out what the reasons for the view were --
8 A. Yes, my Lady.
9 LADY SMITH: -- and they were rational, you can take account
10 of those reasons.
11 A. Yes. Yes, my Lady, that's --
12 LADY SMITH: Perhaps use them to inform your own questioning
13 of the person.
14 A. Yes, yes.
15 LADY SMITH: Mr Peoples.
16 MR PEOPLES: That's what would happen now as opposed to what
17 probably happened in some of the period when Kerelaw was
18 operational, in terms of recruitment.
19 Can I go to the report itself, just briefly. As
20 I say, we will hear tomorrow, but the report itself is
21 GLA.001.001.0297, and I think just at this stage,
22 because I think the Council and the Partnership accept
23 the conclusions --
24 A. Yes.
25 Q. -- of the report. And indeed you have described what

1 happened. But if we look at the report, and go to,
2 I think it is perhaps sufficient to go to page 13 of our
3 document, which is towards the foot at paragraph 1.40,
4 which is headed 'Analysis and conclusions', do you see
5 that?
6 A. Mm-hm, yes.
7 Q. Can I just read that for you:
8 'The Inquiry concludes that abuse of young people
9 did take place at Kerelaw after 1996 and that physical
10 abuse was prevalent, although it did not involve all
11 staff. Weaknesses in TCI training contributed to poor
12 practice that was often abusive. The circumstances that
13 allowed abuse to happen comprised a complex mix of
14 cultural factors, including an overemphasis on control.
15 There were cliques and factionalism and inappropriate
16 relationships, which inhibited challenge and attempts at
17 change, for which there was limited capacity. There was
18 a lack of strategic direction both in Kerelaw and in
19 social work headquarters, and no united sense of
20 purpose. Training did not support culture change, as
21 there was no shared view of the kind of organisation
22 Kerelaw should be. There was no robust system for
23 performance management and supervision of staff was
24 inadequate. The complaint system was inconsistent and
25 poorly monitored and there was little follow through

1 from fact finding investigations of young people's
2 allegations. Inspection did not stimulate culture
3 change at Kerelaw. Criticisms that were made were
4 insufficiently followed through by Kerelaw, the Council
5 or, until after 2003, the inspection agencies.'
6 At 1.41:
7 'Glasgow City Council's stewardship of Kerelaw was
8 lacking in important respects. Local government
9 reorganisation created serious financial problems for
10 the Council and distracted senior managers from the real
11 issues at Kerelaw. External management was
12 inappropriately delegated and inadequately carried out.
13 Poor professional relationships at senior level in the
14 social work department compounded the problem.
15 Proposals for the redevelopment of Kerelaw were
16 a long-term aspiration from 1996 onwards, which may also
17 have been a distraction. The Council's investigations
18 from 2004 onwards were robust, but could have been
19 better handled, and would have benefited from closer
20 quality control of documentation. Staff were not well
21 supported during the investigations and disciplinary
22 processes. The quality of information management by the
23 Council and the adequacy of records relating to young
24 people in care were a cause for concern. Overall, there
25 was a significant failure in leadership and management

1 that led to the relative neglect of Kerelaw and, as
2 a consequence, the dual abandonment of those who lived
3 and worked there. That failure did not occur only in in
4 Kerelaw's final years: it grew over many years under
5 changing circumstances and different management
6 regimes.'
7 The Council didn't take any issue with that, did
8 they?
9 A. No.
10 Q. No. I am not going to go into why they have reached
11 that, we can no doubt explore that tomorrow, and I think
12 unless there is anything you want to say at this stage?
13 A. No.
14 Q. What I did want to do, before we conclude, was just to
15 go back to the question of restraint.
16 A. Mm-hm.
17 Q. You talked about a change in 2016 promoting personal
18 behaviour, and I think what used to be called 'physical
19 restraint' is now 'safety hold'?
20 A. Yes.
21 Q. That's the terminology that's now used.
22 Can I just get to the bottom of this. What is
23 actually the difference between TCI and PPB?
24 LADY SMITH: We had better spell out what TCI and PPB stand
25 for.

1 MR PEOPLES: Therapeutic Crisis Intervention was a method
2 that the Council introduced from the mid 1990s through
3 to 2016, presumably, with some adaptations.
4 Then there is Promoting --
5 A. Positive Behaviour.
6 Q. -- Positive Behaviour is the current approach.
7 A. Mm-hm.
8 Q. Both, I take it, involve, at times, physical
9 intervention, can I put it that way?
10 A. Yes. So the main difference between TCI and Promoting
11 Positive Behaviour -- well, there are practical
12 differences and then there are scrutiny differences.
13 So the main difference is that Promoting Positive
14 Behaviour has a much clearer focus on de-escalation and
15 it is three and a half days' training and most of the
16 training is about that understanding, emotional
17 containment and understanding of where young people are
18 and what might be contributing to challenging behaviour,
19 the presentation of challenging behaviour.
20 And then there are a range of techniques that are
21 taught that are about de-escalation, things like what's
22 called 'planned ignoring', so there are some behaviours
23 if the young person is safe and is not causing a risk
24 from other young people, you actually just remove
25 yourself from the situation, because again evidence

1 tells you that they will work through that kind of
2 emotion and if you intervene physically you are much
3 more likely to escalate.
4 There are a range then of de-escalation techniques.
5 The first bit is the bit on understanding the
6 emotions, and nurture.
7 The second bit is de-escalation.
8 Then only in the set of circumstances where the
9 young person is causing a serious risk to themselves or
10 other young people is there a physical intervention.
11 The second big difference is that TCI was something
12 that we bought in from the States, and in terms then of
13 scrutiny and quality assurance it was something that was
14 governed in a different country.
15 The Promoting Positive Behaviour was actually
16 developed by Clyde Valley, a consortium of Local
17 Authorities, so it involves eight Local Authorities and
18 two health boards, and it was also validated by Robert
19 Gordon University, most crucially, the physical
20 intervention element of it. So it is a programme that
21 has been built on experience, that has quality assurance
22 attached to it, and it is governed here in Scotland.
23 And it is across all of those Clyde Valley Local
24 Authorities.
25 So it is quite different in terms of the

1 requirements in relation to scrutiny and quality
2 assurance.
3 Q. Can I just then get down to a situation -- let's just
4 say there is a situation where physical intervention is
5 required, though.
6 A. Yes.
7 Q. Under TCI, as I understand it, the young person could be
8 put in a prone position.
9 A. Yes.
10 Q. Using a number of staff, two perhaps, and therefore they
11 would be lying flat, face and chest down, and back up,
12 and that would be seen as permissible --
13 A. Mm-hm.
14 Q. -- if intervention was required. Can that still happen
15 under PPB?
16 A. No. Prone physical intervention isn't part of PPB.
17 Q. The days when people were -- I think the expression was
18 sometimes used at the time at Kerelaw -- 'decked' --
19 A. Mm-hm.
20 Q. -- or 'brought down', 'taken down'?
21 A. Mm-hm.
22 Q. If they are taken off their feet, it doesn't involve
23 them being prone?
24 A. No, it doesn't.
25 Q. The supine position, the other way --

1 A. Yes.
2 Q. -- that's the way to take them down?
3 A. Yes.
4 Q. So that they don't have a situation where if they
5 struggle, for example, that they might feel that they
6 are having breathing problems or issues, or feel that
7 they are in some way going to get panicked because of
8 the position they are put in?
9 A. Yes.
10 Q. But they are in the supine position, they are still
11 being held --
12 A. Yes.
13 Q. -- by what, two people?
14 A. It is normally two people, yes. Yes.
15 Q. Are they held so as to prevent the movement of their
16 arms and the movement of their legs?
17 A. If that presents risk to themselves and others.
18 So it is not necessarily prescribed in terms of the
19 individual circumstances, because you also have to take
20 into account -- so each young person has to have a risk
21 assessment --
22 Q. Yes.
23 A. -- because again, individuals, there might be, we have
24 young people in our care who for medical reasons we
25 can't and wouldn't physically intervene.

1 Q. So you have already assessed them for their suitability
2 for PPB physical intervention?
3 A. So we have a safe care plan for all young people and
4 part of the safe care plan is about in the event -- how
5 we would -- because each young person also has different
6 deescalation techniques and there are different triggers
7 for each young person, so your safe care plan --
8 Q. Can someone be barred -- can there be a situation where
9 staff are barred from using physical intervention on
10 a particular person, and if so how on earth do you deal
11 with them? It is a bit of a conundrum, isn't it?
12 A. 'Barred' is probably not the terminology I would use.
13 Q. Sorry, I am trying to get to the essence of what --
14 A. Yes, there are some young people that you have to be
15 really careful with, and de-escalation for them is
16 always going to -- well, for all young people, that's
17 what we do first.
18 The other -- sorry, and I should have mentioned, the
19 other important element of PPB is the debrief.
20 Q. Yes, afterwards?
21 A. Yes, afterwards.
22 Q. But that was a feature of TCI as well?
23 A. But it is related to that quality assurance piece within
24 PPB, so your external manager has to provide evidence of
25 debrief, and the debrief is for the young person as well

1 as the staff.

2 In TCI the debrief was for staff.

3 Q. Yes, so the young person now has a role --

4 A. Has a say, yes.

5 Q. -- and a say in the debriefing as well --

6 A. Yes.

7 Q. -- so they can express views?

8 A. Yes.

9 Q. The one very big practical, just in terms of techniques

10 is it used to be under TCI it was the prone position --

11 A. Yes.

12 Q. -- whereas now that's not permitted?

13 A. Yes.

14 Q. You have to find another way to bring them to the floor?

15 A. Yes, you have to find another way.

16 Q. If you like. Is that fair to say?

17 A. It's also not always the floor, it is not always the

18 floor.

19 Q. Well, no, if you have to bring them down for one reason,

20 to the floor, you certainly will not have them face

21 down?

22 A. You will not have them face down, no.

23 Q. If you follow the PPB training?

24 A. Yes.

25 Q. There may be other ways to safely hold them without

1 taking them to the floor?
2 A. Yes.
3 Q. I know with young people there is something called
4 a 'cuddle hold' --
5 A. Yes.
6 Q. -- which is that you can hold them with your arms round
7 them?
8 A. Yes.
9 Q. Maybe if you have a 15 or 16-year old that's not quite
10 so easy to do?
11 A. Yes.
12 Q. Is this how you are saying it operates?
13 A. Yes, that's how Promoting Positive Behaviour operates.
14 It is also something that happens really
15 infrequently in terms of that physical intervention.
16 Q. We are not in the days that restraints are a daily
17 occurrence --
18 A. No.
19 Q. -- because people were saying that at Kerelaw, that that
20 was a daily occurrence?
21 A. Yes, yes. No, we are not in those days.
22 Q. Are you saying that in the housings it is a relatively
23 rare thing now to have physical intervention?
24 A. Yes, it is, yes. And the de-escalation techniques work
25 much better, and again if you are six to eight bedded,

1 de-escalation, and also the physical environment, lends
2 itself to de-escalation. So there are places within our
3 children's houses where young people can be safe without
4 us having to physically intervene, and that wasn't
5 always the case in residential child care. So the
6 physical environment allows for de-escalation.
7 Q. I take it, just for the avoidance of doubt, TCI
8 training, in terms of where physical intervention was
9 appropriate, it was not to involve pain-inducing
10 techniques, wristlocks, anything like that, and I take
11 it that any techniques that can be used under PPB should
12 equally not involve any form of pain?
13 A. Absolutely not, yes. That was the change to TCI, that
14 was one of the things that -- attractive is the wrong
15 word, that was one of the reasons that the Council and
16 Strathclyde were looking at TCI, was because it was
17 a move away from the use of pain.
18 Q. Yes. But they didn't have any -- well, there was a bit
19 of training, we heard, but not consistently through the
20 life of Kerelaw. For most of Kerelaw's existence, until
21 the mid 1990s, there wasn't restraint training, proper
22 restraint training for all staff, is that not the
23 reality?
24 A. Yes, that is the reality, yes.
25 Q. And also for most of its life you didn't have trained

1 staff?
2 A. Yes, that's right.
3 Q. But you have told us now, obviously, what happens and
4 you have told us you have moved on to another form of
5 safe holding where it is required --
6 A. Yes.
7 Q. -- but it doesn't involve pain and it involves putting
8 them, if necessary, into a supine position --
9 A. Yes.
10 Q. -- if they have to be on a floor?
11 A. Yes.
12 Q. I suppose you can't rule out that if they are in
13 a particular state they could potentially still suffer
14 some kind of injury, not deliberately, but it is not
15 something you can rule out?
16 A. It is not something that you can rule out, but again
17 there is -- that's partly why we partnered with Robert
18 Gordon on it. So there is quite a lot of science about
19 biological -- apologies, I can't quite remember the
20 discipline within science, where it is about the body,
21 and the shape of the body, there is quite a lot of
22 science going into the kind of physical intervention you
23 can use.
24 Q. To reduce the risk of even accidental injury --
25 A. Yes.

1 Q. -- in the course of what is an attempt to achieve the
2 compliance with the PPB --
3 A. Yes.
4 Q. -- techniques?
5 A. Yes.
6 Q. I will just finally do this, one of the points that was
7 made by some staff who responded to allegations about
8 inappropriate restraint, and we may hear something to
9 this effect in this chapter, is that it is all very well
10 to theorise about how you should carry out a textbook
11 restraint or a hold, that's fine in theory, but if you
12 are in the heat of a situation it is not so easy,
13 particularly if you don't know what response you get
14 from the individual, and that it is all very well for
15 people to say this is the way should you do it, textbook
16 style, about you in reality it could be sometimes
17 difficult to meet the standards, or the theory.
18 Is that still something that would be a valid point
19 to make?
20 A. I would be cautious if that point was being made to me,
21 because that would suggest that the person is not
22 fully --
23 Q. Familiar with --
24 A. Yes.
25 Q. -- how to apply the new --

1 A. Yes.
2 MR PEOPLES: That's fair enough.
3 I think that finishes my questions for you, Susanne,
4 and just to thank you for coming and answering many of
5 my questions.
6 Thank you very much.
7 LADY SMITH: Susanne, let me add my thanks, again you have
8 come and allowed us to interrogate you at some length on
9 matters of which you are expert though, so it has been
10 really so helpful to hear from you today. I am
11 delighted to be able to let you go and now rest.
12 A. Thank you, my Lady.
13 LADY SMITH: You will no doubt be tired after all this.
14 Thank you very much.
15 A. Thank you.
16 (The witness withdrew)
17 MR PEOPLES: Well, I think that's all for today.
18 LADY SMITH: We will stop now for today, and tomorrow
19 morning we will be going on to --
20 MR PEOPLES: Eddie Frizzell.
21 LADY SMITH: -- Eddie Frizzell.
22 MR PEOPLES: If we have time there is other things we can
23 also do.
24 LADY SMITH: As you have trailed, that means we are moving
25 to Kerelaw, which of course we have talked about a bit

1 today?

2 MR PEOPLES: Yes, he will obviously be speaking about ...

3 not about Larchgrove.

4 LADY SMITH: Thank you very much.

5 MR PEOPLES: Sorry, I should say he may say something about

6 it, but not as the report.

7 LADY SMITH: I won't stop him.

8 Very well, I will rise now until tomorrow morning.

9 (4.12 pm)

10 (The Inquiry adjourned until 10 am the following day)

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3 I N D E X
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5 Susanne Millar (sworn) 1
6 Questions by Mr Peoples 2
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