Scottish Child Abuse Inquiry

Witness Statement of

Eddie FRIZZELL

Support person present: No.

1. My name is Eddie Frizzell. My date of birth is [redacted] 1946. My contact details are known to the Inquiry.

Background

Chief Executive of the Scottish Prison Service

2. My career was in the UK civil service. I was Chief Executive of the Scottish Prison Service (SPS) from 1991 until 1999. In those days, the UK Government did not fill the post of prison chief in the "English" Prison Service or the Scottish Prison Service with a career prison service person. It was felt (until in the 1990s the Home Office brought in a person from the private sector to run the "English" service) that a senior civil servant should run the prison service, although there were lots of prison people in senior positions. I had a lot of professional prison people at headquarters, so it was by no means the case that it was all bureaucrats who had been sent in to run things. I was an unusual civil servant anyway because I had previously had a management job. I was fascinated by the management challenge and interested in prisons, the dynamics of a disciplined and uniformed service. I felt comfortable around people in uniform. I was very happy to get the job when it was offered to me.

3. My time at SPS was a great journey. Sometimes it was very stressful, but it was the best job I had in the civil service. There were big challenges. The SPS was in some ways an "illegal" organisation in 1991. For example, it had failed to respect the precursor to the Equalities Act. Women were employed and then required to wait until

a post became available at the female prison. There was no opposite sex posting. SPS was not complying with the legislation in place at the time. We were supposedly in negotiation with a highly unreformed trade union, the Scottish Prison Officers Association (SPOA). They were claiming to cooperate but seemed to be doing everything possible to stop women getting posts in male prisons.

4. The statutory framework within which we operated was the 1952 Prison Rules. That demonstrated the low priority accorded by the political process to modernising the system. There had been one or two amendments to the Rules, but we were largely out of kilter with European Convention on Human Rights developments. That didn't stop governors from receiving numerous instructions from headquarters, telling them what they had to do. These must often have been filed on the floor because it was impossible to keep up with it all. It was a highly centralised, not wholly legally compliant organisation in which the blame culture was rampant. It was defensive, and senior people were competing with one another. There was also a macho culture which was partly a legacy of the disturbances of the 1980s.

5. Things had started to improve after the difficulties of the 1980s. By the time I was in post, the problems with prisons were being addressed. There had been riots in the 1980s and there was a still a hangover from that. My predecessor had started a reform programme, which I was happy to pick up and run with. The biggest problem was in many ways the political sensitivities which had to be dealt with in trying to implement change. That was why the powers that be wanted a senior civil servant in charge, someone who understood the politics and could work with ministers.

6. Following Margaret Thatcher's Next Steps Initiative of 1988, SPS became an Executive Agency. That took us out of line management right up through the Scottish Home and Health Department. It gave those of us running agencies a great deal more autonomy. We didn't have to get ministerial permission in respect of operational matters. That helped us to pursue a culture change programme which, generally speaking, was regarded as successful. It was about half way there by the time I left in 1999. Culture in any organisation was and is enormously important and can take a long time to change.

7. The Prison Rules were finally comprehensibly updated in 1993. The 1952 rules still had provision for hanging in them, which was very interesting reading but showed how out of date they were. We introduced opposite sex posting so we became legal under equal opportunities legislation. We were told that this would be a disaster and that there would be assaults in male prisons if we put female officers in them. There weren't. In fact, it calmed the atmosphere in every prison that women went into. The unions even conceded that it had been a success. This was one aspect of the wider culture change that was needed.

8. The new agenda, started by my predecessor, was called 'Opportunity and Responsibility'. It was about empowering prisoners to take a certain amount of decisions about how productively they would spend their time serving sentences. It was partly in response to the difficulties of the 1980s. It was moving forward from a previous policy document, which had been called 'Assessment and Control', which partly reflected the unrest in the 1980s, which are remembered for the notorious "cages" at Inverness Prison. The new agenda was about doing things differently.

9. My predecessor had been in post when a new prison opened at Shotts, which was almost immediately trashed. He invited the press in to show them what had happened to a brand new prison with in-cell toilets and the like. He wanted to demonstrate how difficult the job of the SPS was and the challenges faced. That began a policy of greater transparency. We were willing to talk to the press and let them come in to see what prison was really like, which made SPS less secretive.

10. We had established relationships with the Canadian federal prison service. There was quite a reformist person in charge of the Canadian service. They were going through a modernisation programme which took account of research into what worked in terms of reducing reoffending. We kept in touch with them and learned from them about how prisons might be improved. However, we had to decide what we had to do to deliver on the SPS mission.

11. We committed to a formal process of strategic planning, which applied throughout SPS. Each year, we would develop at Board level a strategic steer. We sent it out to

prison governors and asked them to build a strategy for their prison which took account of that. We would remind them that it wasn't about moving the furniture about in a governor's office and pet projects, it was about what they were going to do within the overall policy context to drive the organisation forward. People responded to that. We got that embedded into the service.

12. It was also about trying to change attitudes and behaviours. When I took up my position in the autumn of 1991, staff at Peterhead Prison were still coming to work in body armour and helmets following the troubles of the 1980s which had included a serious hostage situation there that the SAS had to resolve. The SPS had already started changing Peterhead into a prison with a focus on sex offenders and programmes to address their offending behaviour in a less violent environment than had been the case at Peterhead in the 1980s and which such offenders often encountered in other establishments. So change was happening, and a safer environment for prisoners and staff was created. An early objective was to persuade staff out of the body armour to reflect the new approach and prisoner population. It took time and patience but the helmets were dispensed with first and then finally the body armour.

13. A major training initiative underpinned the Opportunity and Responsibility agenda. We found that if we took prison officers out together off-site for training days, there would be a mix of sceptics and those who wanted to embrace the change. When they returned to their prisons, those who wished to embrace change sometimes found line managers telling them to forget what they learned as it wasn't how things were done. We therefore started to take the line mangers with them so they all got the same message. That actually worked.

14. As part of the "Opportunity and Responsibility" agenda SPS also had a policy of identifying "personal officers" for longer-term prisoners, who were to be the person that the prisoner related to most. Prisoners could talk to their personal officer about how they were going to serve their sentence and other matters. We wanted to re-establish constructive relationships between staff and prisoners. We still needed razor-wire and walls and we still needed rules and regulations about handcuffing and

external escorts, but if you could get positive relationships with staff prisoners were less likely to assault officers and were more likely to engage constructively with the opportunities available during the sentence. So "dynamic security" flowing from better relationships became as important as physical security and that policy did begin to pay off.

15. We also attached importance to obtaining prisoner and staff views. There was a three yearly prisons survey. This involved quite a substantial questionnaire that went to all prisoners and staff. We had a research unit in charge of that. We had a 98% response from prisoners and quite a high return from staff. We asked questions about, among other things, the atmosphere in the prisoners' units and halls and what their top priority was. In every survey, the top priority for prisoners was maintaining family contact through visits. It trumped ending slopping out by a long way. Prisoners were prepared to tolerate slopping out in the Victorian prisons if they could have better family visits. We made that a top priority and we modernised the visiting arrangements over time. We improved visiting arrangements and facilities and that gradually began to work through. We began to get answers saying that there was no tension in the halls and there was a calm atmosphere. The surveys were written up and the staff and prisoners got to see the results. There was quite a similarity in many of the headline things between what the staff wanted and what the prisoners wanted. The staff were keener to end slopping out, which was unpleasant. We got quite far with that but it wasn't completed until after I left.

16. We also introduced standards to be met. For example, prisoners got their underwear washed every day, and better access to showers. More importantly, they also got their own underwear back after washing rather than someone else's. Some of the standards covered the care part of the agenda. The mission statement was: to keep prisoners in custody, to maintain order in prisons, to provide care and to offer opportunities for prisoners to prepare for release. One of the most significant things we did related to health. Nursing officers were qualified nurses who were also discipline officers. It was increasingly obvious that to be a discipline officer, which might involve restraining a prisoner, was inconsistent with being a registered nurse. We decided to civilianise nursing and ask the prison nurses to choose whether they wanted to be a nurse or a

discipline officer. That caused a furore initially, but we managed to get that done with the assistance of the chief nursing officer in the Scottish Office. That helped and improved the quality of care.

17. We also improved the food in prisons by the simple expedient of giving the catering managers a budget. They were given a daily financial allowance and they did extremely well. The quality of the food improved. Prior to that, there were a group of people at headquarters who sent out instructions on what prisoners should eat, with a "dietary scale" dating back to the early 1900s. This stipulated – to the ounce - what prisoners needed to eat every day to stay healthy.

18. I used to emphasise to governors that although we had made improvements in care, we still had to keep prisoners in secure custody and eliminate so far as possible the risk of escape. We reduced the number of escapes but we didn't get them to zero. We couldn't get them to zero because prisoners cannot be locked up in a cell 24 hours a day 7 days a week, and if they are out with an escort security depends very much on how well the escorting officers abide by the rules and procedures.

19. Prison governors fell in my view into three groups, university educated graduates, those with strong Christian beliefs and those who had risen up through the ranks from officer. These groupings were not mutually exclusive. I remember one used to tell me that there was no point in updating the Prison Rules or having standards until we achieved culture change. I would respond that there was indeed a point because we would help culture change in stages and by keeping the message strong. They were resourceful people, and such debate was healthy.

20. In some management textbooks it is suggested that culture change takes about fourteen years. I think that it can take longer. It was undoubtedly helpful in that I was able to draw on money from HM Treasury to facilitate the early retirement of prison officers who didn't want to buy into the change we wanted to achieve. Some of them had lived through the riots in the late 1980s, which had an effect of them. A number were ex-soldiers, some of whom were very good, some not. We introduced an induction unit at Shotts for long-termers so that they would settle in better to their

sentences. Generally, I do believe that when I moved on after 8 years I left a much calmer and more values driven prison service, but that is for others to say.

21. We wanted to change the culture among senior staff also and make it more co-operative and we made progress. I engaged someone who had done some consultancy work with us at the beginning of the process, under my predecessor. Just before I moved on, I asked him to do an external assessment on whether there were indeed signs of culture change. There were still all kinds of problems, and some staff would grumble all the time, but he did find that there had been significant progress on a lot of fronts.

22. The SPS is now dealing with a prison population of about 8000. I inherited in 1991 a population of 4700. It then went down somewhat because of changes to sentencing legislation. A lot of prisoners were released because they'd served half of their sentence. Numbers then climbed up again and reached about 6500 in 1999. Despite the continued pressure of numbers since then there has been no return to major riots and prisons have been relatively calm. There have been significant improvements in the condition of the prisons estate, including new prisons coming on stream. Broadly speaking, I would say that there were improvements the 1990s and that the culture was changing. I see further improvements since I moved on. Politicians now entrust prison professionals with the post of Chief Executive, which is a good thing. Also prisons are not on the political agenda in the way that they used to be. My biggest issue in many ways was the politics of it all. It was the 1990s, which saw the steady decline of the then Conservative government and the start of devolution. Until the 1997 General Election it seemed to be the job of the Labour supporting press in Scotland to rubbish what was going on in prisons and make them look soft, and to compare that with the often punitive rhetoric of Conservative Ministers in England. So finding a way through the politics was always a challenge.

Young offenders and potential for abuse

23. When I was Chief Executive of the SPS, we had two young offenders' institutions (YOI) for sentenced males, Polmont and Dumfries. Dumfries mainly held the 16- to 21-year-

olds who were serving lengthy sentences. One of the good things there was that it was possible to run education programmes, as the young offenders were there for a while. I remember presenting education certificates to detainees there. For many it was the first recognition of educational achievement they ever had. The estate was later re-organised and all young offenders are now in Polmont. When I took over, Polmont was in a poor state in terms of its fabric. We put money into modernising it. It was partially upgraded by the time that I moved on.

24. Young offenders are different from adult prisoners. They can be more volatile, but also more vulnerable in some respects, particularly young women who were held in Cornton Vale Young Offenders section. During my tenure, we had a spate of suicides by girls there. There were complex reasons for that, and it was much reported in the press. If we had known for certain what these complexities were, we might have been able the better to tackle the problem. But past life and background; mental health; abuse; drug use; copy-catting; hopelessness; bullying; loss of family contact can be factors in prison suicides, as they can in the community. I am not attributing those reasons to the particular sad deaths at Cornton Vale. There were Fatal Accident Inquiries (FAIs) into the individual cases some considerable time later, after I moved on, which may or may not shed more light on the reasons for the suicides. Four or five girls killed themselves in the space of about three or four months. It was a real challenge for us to deal with that. That was my worst experience as Chief Executive.

25. There can be clusters of suicides, including in other settings like mental institutions. Ideation can be important. Sometimes dramatic attention-seeking can result in suicide by hanging if the person does not realise that [redacted] quickly lead to death even if that was not the intention. Copy-catting – again with death not necessarily being the intention – can result in death. It was a real challenge to deal with what was a cluster in a relatively short period, with heightened emotions in the prison, the media, and the families of those who died.

26. Given the passage of time, I cannot remember the particular steps that we took to address the problem of suicides in Cornton Vale. We reviewed the suicide prevention policy again, which was in itself controversial because it had involved isolating those

who expressed suicidal intent and removing the means of self-harm. This was controversial because understandably it was argued that if you were suicidal before isolation, isolation would make your state of mind worse. We reinforced with staff the need for the rules on observation of inmates on "suicide obs" to be rigorously followed. We removed anything that could be a ligature point in ordinary cells, and we repositioned the window bars at Cornton Vale to be on the outside. There was debate about this, with some arguing that if someone was determined to kill him or herself he or she would find a way whatever preventive measures were taken. There is clinical and social research to back that view up, but not so far as I was concerned sufficient to justify not pressing on with removing access to the means. There is also similar research showing that even professionals cannot predict that any particular person will take his or her own life. It is complex and I am not an expert.

27. There were slightly different regulations for young offenders. The YOI had different visiting committees as well. I can't remember the details now. Broadly speaking, they were just prisons. They had segregation units like adult prisons. They kept the younger generation away from the older generation, but they were run in a very similar way to adult prisons.

28. I'm aware that there could have been bullying going on in the young offenders' institutions. There were assaults on young people by other young people. There were also assaults by young people on prison officers. They could be more volatile and more difficult to reason with. I had two targets, one to reduce the number of assaults on prison staff and another to reduce the number of assaults by prisoners on prisoners. These targets – which applied to adult prisoners and young offenders alike - were difficult to achieve. I would hope that there weren't assaults by prison officers on young offenders, but it possibly did happen. I hope that someone would have spoken up and brought it to my attention if it had. I didn't get the impression that a lot of that went on, but there may have been some of that going on. It would not have been tolerated if it had come to my attention.

29. I think prisons probably did become safer over the period. We did gradually reduce the number of assaults. You can reduce violence of course by locking prisoners up and

keeping them behind their doors. That is counter-productive if you do it unreasonably because the prisoner may assault the member of staff who unlocks the door. We picked up on safety in the prison survey by asking prisoners how safe they felt in their halls. We could interrogate that to see whether things were getting better or worse. Generally they got better.

30. I used to walk around a prison more or less every week. I had a programme agreed in advance. I would see the governor and his team and then walk around the halls, or the other way round. I would talk to prisoners and staff. Prisoners would I think have told me if they had been assaulted as I didn't always walk round with the governor in attendance. I walked around the YOIs as well.

31. The number of under-18s in Polmont is far lower nowadays than during my time. I think there are only about thirty for the whole of Scotland. I'm sure it was about three hundred in my time. I think that's partly due to government policy, to keep young people out of the prison system. There have also been some changes to sentencing policy. The SNP government has paid some attention to the evidence that short sentences are a waste of time if the aim is to do something constructive. They've legislated to - I think - outlaw sentences under a year. They have tried to advance the community disposal agenda. The problem with that is that it costs money. Community sentencing requires a lot of money for social worker supervision. There's a simplistic view that you can find the cash by saving money in the prison system, but you can only do that if you close a prison. Reducing numbers by a few hundred distributed around the system doesn't close a prison so a radical switch to community disposals never really gets taken forward properly. And they are not very popular with the average voter in any case.

Background to establishment of the Independent Inquiry

32. The investigation was commissioned in the early months of the first SNP administration at Holyrood. There had been a lot of adverse publicity around the way that Glasgow City Council had handled allegations of abuse at Kerelaw and its closure. There was a figure of forty people, including core staff, said by the Council to have been involved in abuse. Having been a civil servant, I could imagine the reaction in government when all this came out. The SNP government had just taken over and Glasgow was a Labour Council. From what I saw, there had been to-ing and fro-ing between the Scottish Government and Glasgow City Council, and I think that the Scottish Government didn't feel that they were getting all the necessary information from the Council.

33. Glasgow City Council had already carried out an investigation into what had occurred at Kerelaw. My recollection is that there was a report as a result of that investigation. The Council had come out with the figure of forty people being involved in abuse. There was an outcry from trade unions and staff about labelling forty people as abusers. As it turned out, it was difficult to justify the statement that forty people were abusers. There were certainly a lot of people who knew what was going on and should have done something about it, but it turned out that figure of forty couldn't really be backed up according to the information that the Inquiry obtained.

34. In spring of 2005, Glasgow City Council ordered an investigation into the external management of Kerelaw which reported to committee in December 2005. The Minister for Children and Early Years was writing to the Leader of the Council, asking to see copies of that report. A further report was submitted by Glasgow City Council to the Scottish Ministers in August 2007. I did see that report in the course of the Independent Inquiry. It was fairly short, said that Kerelaw was closed and that was that. It didn't draw any learning. The Minister didn't think it was satisfactory and that was what led to the Independent Inquiry being set up. There was clearly some tension between the Council and the SNP administration.

35. I was appointed to lead the Independent Inquiry into Abuse at Kerelaw in 2007. It was jointly commissioned by the Scottish Government and Glasgow City Council. They agreed to pay me a fee. I think it was funded from the Scottish Government budget, and I don't know whether Glasgow City Council had to contribute. We started our investigation at the end of 2007. The politicians in central government seemed to think we could get the whole thing done in six months. I had to keep dampening down their expectations in terms of timing. It took several months just to get premises, and to get records from Glasgow City Council.

36. The Inquiry was commissioned in November 2007 and we published the Report in April 2009. The purpose of the Independent Inquiry is set out in the Executive Summary of the report at page 3 and the terms of reference at Annex A. I can't remember being consulted about the terms of reference. I think they were simply handed to me. I presume they were agreed jointly by Glasgow City Council and the Scottish Government. They provided a useful checklist of what we needed to cover.

Appointment to Independent Inquiry and other members of Independent Inquiry team

37. I am not sure how they came to appoint me as Chair of the Inquiry. Someone in the Scottish Government probably suggested my name because I had been in charge of prisons and had retired from the civil service. I think that's quite often how these things come about. I was approached by the person who was at the time the Deputy Director in the relevant part of the Scottish Government.

38. As to the rest of the Independent Inquiry team, it was suggested to me that I would need social work input, which I agreed with. We were a small team. In addition to me, there were three further investigators. Dr Ingrid Clayden, Katie Lamb, and Simon Glassford. Katie's background was in social work and she was nominated for the role by the relevant department at the Scottish Government. She was a highly experienced and effective social worker based with the social work services group at the Scottish Government. Glasgow City Council nominated Simon, also a social worker, working for Glasgow City Council. I don't think he was in a field role at that point, but I believe he held such a role in the past. He was based in the headquarters of the social work

department so he was a route into the senior people there, which was tremendously useful. Ingrid was an administrator whom I knew previously in her role in the HR department of the Scottish Executive. I think she was due to move job at that time and she was suggested to me. That's how these things come about. It's often about who is capable and available at the time. Evelyn McKenna, whom I also knew from the civil service, was our office manager.

39. We had a Reference Group. We didn't have regular meetings with them, but I think we met with them two or three times. The people on the Reference Group were: Anne Macdonald, professional adviser to the National Reference Group; Tom Shaw, former Chief Inspector of Education and Training in Northern Ireland and also independent expert appointed by Scottish Parliament to lead the Historical Abuse Systemic Review into Residential Schools and Children's Homes in Scotland 1950 to 1995; Anne Black, independent social work consultant; and Ian Milligan, assistant director at the Scottish Institute for Residential Child Care.

40. I'm slightly hazy now on the role of that group. We consulted them about how we might go about our work. At the beginning, it was partly to do with the rules of engagement. They gave us advice about how difficult it would be to get young people to give evidence, particularly those who may already have given evidence to the police. A lot of young people didn't want to go over it again and again. A number of adults didn't particularly want to go over it again either. The Group gave us some good advice on that and on how we might carry out the interviews. I think we subsequently went back to them with our initial conclusions and they gave us comment and input on that. It wasn't a monthly meeting or anything like that. I don't recall there being much written output from the Reference Group until draft report stage.

Written evidence

41. We didn't instruct any expert reports or receive any expert input, other than from the Reference Group. However, we did do a lot of reading of other inquiries into child abuse, such as the judge-led inquiry into the death of Victoria Climbie published in 2003 and the Edinburgh Inquiry into Abuse and Protection of Children in Care

published in 1999. We didn't consider a huge amount of written evidence. There was a Strathclyde University-based academic, who sent us quite a lot of helpful information. Katie knew of him from the past and recalled him as having views about looked after children. I can't remember exactly what his agenda was, other than it was in relation to policy and possibly being against the concept of looked after children. I recall he sent us a paper.

Visits to residential units

42. We visited Ballikinrain Residential School near the Campsies, which was run by Crossreach. We also visited Kibble Education and Care Centre in Paisley, which had both a secure unit and an open school. We wanted to understand what they saw as the issues in running those kinds of institutions. I was also interested to see what the Kibble secure unit was like in comparison to a YOI. I wanted to see what the security was like and what the rules, regulations and regime were. I wanted to know whether children were being searched and whether staff had to use interventions and holds.

43. We walked round the schools and had some interaction with the children, but we didn't interview any. Those visits were very helpful. They were educational visits for me. Kibble seemed to be a tightly-run ship. The staff were able to answer all of our questions. I didn't get the impression that they weren't being open with us about what the difficulties were.

Records

44. The main trouble when it came to obtaining files was the state of Glasgow Council's records. That's partly what led to the Inquiry taking so much time. We accessed a large volume of paper and some electronic records. The Independent Inquiry's base was in Edinburgh, but we were also given access to rooms in Ingram Street, Glasgow. That was where we looked at Glasgow records, and interviewed some people. Files were made available to us there. There were too many records for us to examine every one, but we went through them and sampled them. The quality of the record keeping for

individual children didn't seem to be as good as it might have been. We would ask for records and often couldn't get them, because they weren't easily to be found.

45. I've now forgotten what we did not have, but we'd asked for some particular records and they didn't know where they were. Someone then said they were all in a room somewhere, boxed up. I have a recollection of going into a grotty room where a whole lot of records from Kerelaw were stored in boxes. We sampled some of them to see what condition they were in. I remember opening boxes to look at paper files, but I can't remember what these were. It might have been that we were trying to see papers about complaints because that was a big issue. Some young people from Kerelaw would tell us that they had made a complaint, but often we could not find a record.

46. We struggled to get the information of a factual kind we would have wanted to have, but not because of unwillingness on the part of Glasgow City Council. There were gaps in the documentation we obtained. There didn't seem to be an easily accessible central record of every person who had attended Kerelaw, chronologically, through the time of its existence. If a record had existed, the papers no longer did. It was patchy and meant that we didn't have a proper record of everyone who had been resident at Kerelaw. There was no complete picture. There were better records of staff because they were on payroll. Payroll and human resources data made identification of staff much easier than identification of residents.

47. We did get to see material from Glasgow City Council's investigations into Kerelaw. This was helpful initially and allowed us to identify people to interview and areas to look into. I don't remember an inventory of what material we saw. We knew what we had and what we got. Getting one thing always led us to ask for something else, but I don't remember having an index of everything. We may have had.

48. All the records we obtained were returned to Glasgow City Council at the end of the Inquiry. I'm not sure what happened to our own papers. I remember there being a lot of shredding at the end so that we didn't have papers lying about. There wasn't yet a very sophisticated electronic records system within the Scottish Government at that time, but I think anything that we did retain would have been passed on to the Scottish

Government. I kept some of the things that we were told on a hard disk. I had to be careful about names because I didn't want them to go anywhere, and used initials, but that really was all that I kept.

Witnesses to the Independent Inquiry

49. We were able to find the names of potential witnesses within Glasgow City Council's investigations. We then found the names of other members of staff. People we spoke to would provide names of other people who might have information. Witnesses were therefore a mixture of names that we gleaned from the Glasgow documentation, some people who contacted us, and names that we were given by people we spoke to. We would ask witnesses if there was anybody else whom they thought we should contact. We heard from a lot of staff and that was where much of the information in the report came from. We were not considering individuals in our findings. Witnesses remained anonymous, as we agreed, and we had no powers to compel them to speak to us.

50. In the course of the Inquiry, we conducted 166 interviews. We shared them out among me, Ingrid, Katie and Simon and generally two of the team would be present. We deployed an inquisitorial approach. We didn't record the interviews, but we did take notes. We didn't retain our interview notes after publication of the Report..

51. We spoke to 55 former Kerelaw employees, including five former Principals or acting Principals, and other ex-members of its senior management team. Contact with former members of staff was made via the Councils, Glasgow and North Ayrshire. The Inquiry also received oral evidence from one former and two then current Glasgow City Councillors, and former senior managers in Glasgow City Council's Social Work Department, including people directly and indirectly involved with the external management of Kerelaw from 1996. We interviewed former and then current senior corporate managers in Glasgow City Council, including the then current Chief Executive. We interviewed all but one of the joint investigation team plus those who carried out the Millerston investigation in the Spring of 2004. We interviewed a number of people in the HR, Finance, and legal functions in Glasgow City Council, who had involvement with Kerelaw in relation either to policy or to the Council's investigations

and/or disciplinary actions against staff. In total, we interviewed 35 current or former Glasgow City Council managers, including 5 who chaired disciplinary hearings.

52. We were unable to speak to one retired person, who during the period covered by the Inquiry had at different times been both Director of Social Work and Director of Education at Glasgow City Council and who had been involved in the decision to close the school. He ignored us so I assume that he didn't want to assist. He didn't engage at all.

53. We spoke to a number of people from other organisations. We spoke to Scottish Government civil servants who worked in the Children and Young People policy area of the Government. We spoke to representatives from the unions, Unison and the Educational Institute of Scotland. We spoke to the Care Commission and Her Majesty's Inspector of Education (HMIE). We were unable to speak to a former senior social work inspector, but I can't remember his name. He was someone else who just ignored us. I can remember we were fairly indignant about it at the time. I can't remember there being anybody else who we weren't able to speak to when we wanted to do so. 99% of the key people (not residents) we wanted to speak to were willing to speak to us.

54. We tried to contact former residents via social work. A few of the young people we spoke to were people whose names were known and might even have been in the public domain. One of them had made a number of public allegations about abuse at Kerelaw and was pursuing a court case, as I recall. There were one or two young people like that and they encouraged some others to come forward.

55. We spoke to 22 young people in total. We thought we had over thirty, but twelve didn't turn up on the day of their interviews. That number is really disappointing. Trying to get people to come and give evidence took a long time. Persuading former residents to come forward and give evidence was very difficult. At one point, we advertised on *Radio Clyde* to encourage them to come to us. It produced one or two people, but not a lot. My biggest regret about the report is that, in my view, we didn't get enough former residents talking about their experiences. We consulted with the Reference Group and

other professionals about engagement with them. The Group said that the problem was that they'd probably spoken to other investigations before. They may have been involved in police enquiries. Often abused people do not want to relive it by going over it again. It must be difficult for people who have been abused to bring it all back.

56. I do recall some sceptics saying that complainants were just doing it for the money. It was not an impression that we got from the former residents who were prepared to speak to us. I don't believe that they were just looking for compensation. I don't think that was the motivation for people coming forward to make complaints.

57. We did hold a list of witnesses. We used their initials when we referred to them. We wanted to anonymise the Report. I can remember some of the names, but we were very clear that we wouldn't reveal identities. It was fundamental to our rules of engagement and one of the reasons that people were prepared to be so open with us.

Potential abuse at Kerelaw and consultation with the police

58. We did not receive any information that justified passing to the police. We didn't get any records from the police or the Crown Office and Procurator Fiscal Service. One of the issues was that the police investigation, Operation Chalk, had been kept separate from the Council's investigation. The police had investigated criminal behaviour, particularly in relation John Muldoon and Matthew George. Muldoon was a unit manager, who had been convicted and sentenced to two and a half years imprisonment. George had been sentenced to ten years imprisonment but had been released on interim liberation at the time of the Independent Inquiry, pending an appeal.

59. We were very clear that we weren't getting involved in any of that. It was beyond our remit and in any case a matter for the justice system. The police were investigating. My recollection is that between twenty and thirty reports had been sent by the police to the Procurator Fiscal. There was consultation with Crown Counsel, following which it was decided that there would be no proceedings against the vast majority of accused

people referred to them. I presume that Counsel took the view that there was insufficient evidence to get convictions.

60. We did have a meeting with the police to discuss their impressions of Kerelaw to help us build a picture. There were things going on that shouldn't have been going on, but it was unclear whether they were criminal offences. The police had been narrowly focused on investigating particular alleged offences. I think that was where they found it difficult to put together evidence that would satisfy the Procurator Fiscal. We didn't receive any allegations of sexual abuse at any point in our investigation, but in that regard there were references to Matthew George, John Muldoon and a female care worker, who had been acquitted of sexual abuse of a minor. Nobody that we met in the course of the Inquiry suggested to us that there had been sexual abuse. It was all about physical abuse, spanning a whole range from the inadvertent to the quite deliberate in the context of a culture of control.

61. The investigation by Glasgow City Council was quite wide-ranging in terms of the span and kind of abuse at Kerelaw. It was a very broad brush finding. As I noted earlier, they reached a figure of forty staff being involved in abuse. People that we met took exception to that. It was seen alongside the conviction of the two people for sexual abuse. There was a suggestion that other abuse referred to might have been sexual and that caused a lot of resentment. The finding wasn't clear. It may be that there was sexual abuse occurring on a wider scale, but we didn't pick up on it and I think that we would have. We couldn't rule out that more sexual abuse had occurred than resulted in court proceedings, but there was nothing that led us to believe that it was rife. You can never be absolutely certain, but it didn't appear to us to be the case. The fact that it had been implied by the Glasgow report was a source of particular grief to the former staff that we interviewed.

62. We were told about physical and emotional abuse. We heard about straightforward assaults that were not connected to the use of restraint under the Therapeutic Crisis Intervention (TCI) policy. For example, children would be yanked by the hair or dragged upstairs to bed. We also heard about restraint being immediately adopted if there was an issue. There was often no disposition to try the de-escalation staff were

supposed to attempt under TCI to ensure that physical restraint was a last resort. Emotional abuse did seem to be rather widespread. We heard about staff miscalling children, saying things like, "No wonder your parents didn't want to have you," or, "No wonder you can't stay at home." There was some evidence that this kind of belittling of children took place while restraints were being carried out.

63. We didn't specifically ask about violence between the children themselves. The assumption was that there would be some and we did hear about fights being broken up. There was no suggestion that children had a role in controlling other children. The abuse that we heard about did not appear to be organised. It was the behaviour of individuals in a context where they believed that what they were doing was okay.

Therapeutic Crisis Intervention Technique

64. Kerelaw adopted the TCI model for preventing and managing challenging behaviour in 1995. At best, there were staff who didn't apply TCI properly. The use of the word 'therapeutic' was a misnomer in the case of Kerelaw. Physical restraint was meant to be a last resort, but it was clearly a first resort in the case of some members of staff. There were people who genuinely wanted to apply TCI properly and get it right. There were also people who thought they could use TCI to inflict some pain. There were also people who didn't bother with TCI at all and just dragged children up the stairs or bounced them off the walls. Staff told us that they had witnessed that. The picture we got was that there was very much a range of staff behaviours. One or two of them said that they hadn't practised TCI as well as they might have. There was quite a lot of self-awareness on the part of some of the staff we interviewed, who regretted the way that they had behaved.

65. Prior to TCI being introduced at Kerelaw, the staff had received training in restraint which was very similar to restraint used in prisons. It was about putting pressure on wrist joints and thumbs and usually required three people. It was about inflicting pain. In the prisons context one person is supposed to hold the prisoner's head, telling them that if they stop moving, it won't hurt. It need not be painful if the person being restrained doesn't struggle, but it's definitely painful if they do struggle. TCI was

supposed to replace that kind of restraint, but there was still a legacy of pain infliction by some staff. Documentary evidence about the nature and quality of training in TCI was slight. The only evidence of TCI training came from what we were told by the staff that we interviewed.

66. There were occasions when staff hadn't had their TCI refresher training for far too long so they restrained clumsily and young people got hurt. There was some testimony that children were pushed down on carpets and had their arms or legs pushed up their backs. That should not have been happening.

67. I think there were records relating to the use of TCI, but we didn't see very thorough records of how often it had been used and when. In my capacity as a member of the Board of Governors at Rossie Young People's Trust, information on any use of physical restraint is available to me. They should have had such information at Kerelaw. They should have been looking at that and comparing each of the residential units. The point is that having the information leads to questions being asked. There might be a good answer to those questions, such as the presence of one highly disruptive young person, which may distort figures, but they didn't seem to have that kind of overview at Kerelaw.

Culture at Kerelaw

68. Kerelaw was closed by the time that we started our investigation. The Council decided to close the school in October 2004. The open school closed in December 2004 and the secure unit closed in March 2006. We were required to investigate the circumstances that arose leading to the allegations of abuse and closure of Kerelaw. We therefore had to go back somewhat. The key date was local government reorganisation in 1996. Kerelaw School had been within the North Ayrshire District Council area. Strathclyde Regional Council covered that area and carried out inspections, as did the local Council. The social work and education hierarchy responsible for Kerelaw prior to 1996 was within Strathclyde Regional Council. Kerelaw then became an orphan. Local Government reorganisation abolished Strathclyde Region and kept the district Councils. I don't think North Ayrshire Council

wanted to be responsible for Kerelaw. It was probably expensive to run. It was therefore given to Glasgow City Council in 1996. I don't think Glasgow particularly wanted it either, and was forty miles away. That was an important change, but it doesn't mean that everything was perfect in Kerelaw up until that point. It wasn't.

69. Our key point of reference was from when Glasgow took over stewardship of Kerelaw, but we were told things that pre-dated that. It was clear that Kerelaw's history as a List D school had influenced its culture. We were told that there had been a macho culture from the early days of the school onwards. We were told Kerelaw recruited a number of staff who had been made redundant from the Ayrshire steel industry. Staff were recruited for their ability to handle difficult and violent fifteen year old boys, and they took pride in being able to do so. That seemed to be a culture that had become embedded in Kerelaw. It wasn't to the exclusion of people who tried to do things differently, but being able to deal with the most problematic children was the way that they were pleased to be seen.

70. Glasgow City Council took over the running of Kerelaw in 1996. In 1997, neighbouring local authorities raised concerns over allegations relating to the use of restraint. There was some follow-up to that but little lasting impact. People would refer to the Kerelaw riot of May 1998, but we never quite got to the bottom of what that was. We didn't see any documentation relating to that, but it was clearly imprinted on the folk memory that there had been some kind of disturbance at night-time. It was mentioned in the context of staff, who used it as yet another example about what a terrible time they had had looking after the young people and why there needed to be control. Night staff were often an issue. There were people who only wanted to work nights, which is not necessarily a good thing. It resulted in a lack of integration with day staff. I seem to recall that managers did try to integrate them a little more at some point. A number of the complaints from residents were about night staff, who were not seen by everyone else and were of course operating at night. In 2004, a night worker was convicted of assaulting a female resident.

71. There had been an investigation into the Millerston Unit at Kerelaw in 2004. John Muldoon was the unit manager of Millerston. His philosophy was that they should have

a policy of zero tolerance. He ran the tightest of tight ships, backed up by a degree of force. The investigation had come about because of allegations that Muldoon was bullying staff. At that point, nobody had broken ranks over what was being done in relation to controlling the residents. That opened the floodgates and precipitated the later investigations.

72. The Millerston investigation was reported to the directors of social work and education in June 2004. It recommended further investigation and reporting to the police. In the summer of 2004, Glasgow City Council formed a joint investigation team with elements from education and social work departments to investigate current and historical abuse. The police were also carrying out their investigation separately. The Council had hoped to make it a joint investigation, but I can understand why the police didn't want that.

73. Kerelaw was quite isolated in that it was forty miles away from Glasgow. If it had been closer, it might have had more attention from the people in headquarters. There were also the kind of tensions you get in many organisations. The Principal of Kerelaw resented the fact that the external manager was a lower grade than he was. This person, whom the Principal regarded as a lower mortal, came down from headquarters to exercise the external management function of the department. The Principal didn't like it. Kerelaw was being increasingly left behind.

74. The people we spoke to were very clear that they felt Kerelaw was a place of last resort for difficult placements. That was illustrated by the number of emergency admissions it received. Many witnesses spoke about that. They frequently received emergency admissions on a Saturday or Sunday night. If the social work department had to take a child out of a situation and had nowhere to put them it was said they were taken to Kerelaw. There would be little or no induction when they did that.

75. There was an attitude of sending children to Kerelaw when there was nowhere else to put them. The staff would never have admitted that it was difficult for them and the culture fed on that. Many of the staff at Kerelaw had taken pride in telling everybody how good they were at being the last resort for children. They had burly ex-steel

workers who could deal with violent fifteen year old boys and girls, who were proud of that.

76. The internal staff culture varied. There were those who were resistant to training in TCI. There was one member of staff who apparently sat through the training reading a newspaper. He thought it was all rubbish. There were some staff who thought that children were being given too much. Many staff didn't feel that way, but there was no unified culture. There were disagreements amongst different kinds of staff.

77. A number of staff we spoke to held up their hands and said that they should have called out the behaviour of other members of staff. That is not easy. People question issues in the Metropolitan Police just now, but you can't get culture change just like that. I'm not excusing people who don't call out these behaviours, but if you're a policeman and you're in a dangerous position, you want your colleagues to come and help you out. If you've just reported one of them for inappropriate language, he's not going to be in any great rush to come and help you. The same is true in prisons. Prison officers have to deal with difficult incidents. If some hang back because another officer complained about them then it's dangerous. I'm not saying that's right, but it explains why it's quite difficult for people to call out behaviours and attitudes that they should be calling out. Kerelaw wasn't a uniformed organisation, but there was a similar feeling that staff had to support each other.

78. There had been quite a lot of undermining of staff at a higher level. There were some counter-cultural people who went to Kerelaw, thinking that they could sort it out. There was a deputy Principal in the open school who believed in a more therapeutic and supportive approach. That didn't go down well with other parts of the Kerelaw hierarchy. She was accused of giving the children too much. She typified the more caring environment that she believed in. She was constantly undermined and eventually she had enough. She was so far as we could see basically bullied out of her job over a period of about eight years. Quite a lot of staff believed in what she was trying to do, but they weren't the dominant ones. The macho culture was winning. The Principal was an educationalist who saw Kerelaw as a school, which it was. His deputy

had come from a hard-faced place in the North of England. He apparently had a more disciplinarian approach so there were divisions at senior level.

79. There was no leadership strategy at Kerelaw. There had been a Principal appointed at one point in the 1990s. He wanted to introduce a strategy for Kerelaw and agree what the aims and ambitions would be. It was a much more balanced approach and he wanted to bring about culture change. The Inquiry team felt that he was on the right track, but there was a lot of resistance to him. He didn't last. I think he eventually gave up. I remember that we met him and spoke to him about his experiences. He was the only one who seemed to grasp that the notion of culture change required leadership and that leadership needed clarity about values and the kind of organisation that was wanted. His attempts to change things gained no traction.

80. That said, there were some good things happening at Kerelaw. A number of young people we spoke to thought that it had been fine and had been good for them. Many staff went in every day to do a good job and it would be very unfair to suggest that they did not. There was something about the culture and the command of the culture that the abusers had that made it very difficult to change it. I was amazed at how well former staff cooperated with the Inquiry and how open they were about that. In some cases, staff did say that they could have done things better and that they regretted it now.

81. At the time of the Inquiry, I remember thinking that the secure unit seemed to have been run somewhat better than the residential school. It emerged in a better light. I think that might have been because there was likely to have been a more disciplined structure around the secure unit. I think there may have been more routines and less scope for children to kick off. I didn't get the impression that it had been more oppressive. The Millerston Unit was in the open school. The complaints and criticisms seemed to come more often from the open school. That doesn't mean that in the secure unit it was all fine. I have no basis for saying that, but it was a more secure environment and maybe there was less scope for bad behaviour by staff to go unnoticed.

Condition of Kerelaw

82. The impression that we gained was that the buildings at Kerelaw were not in great condition. Latterly, there had been discussions about a new Kerelaw being built. I believe that the Council had identified a site for it and it was going to be closer to Glasgow. There were then unresolved disagreements about who would pay for it - the Government or Glasgow City Council. It was batted back and forwards and was then overtaken by events. The Principal who tried to change the culture had been focused on moving to new premises and getting a fresh start with an acceptable culture. It never happened. There was some redecoration of the existing premises which people referred to, but it didn't sound like a particularly nice place.

Recruitment, training, and supervision of staff

83. As I have already noted, it seemed to us that Kerelaw would employ anyone who was big and robust enough to come and deal with the people they had to deal with. Someone we spoke to used the description, "Built like brick outhouses." It didn't seem to be a values-based recruitment process. We didn't get the impression that there was induction that was values-based and which made it clear to new staff how they were meant to behave. Local people were recruited. The criteria seemed to be whether they looked as if they could handle it. Some of the staff were related to each other. If they weren't related, they were sometimes in a relationship. It was unlikely that staff would call out someone they were related to or going home with at night.

84. There were issues when it came to staff training. There was training and development of staff at Kerelaw, but it wasn't being evaluated and didn't seem to make a difference to how some of the staff behaved. The registration of care workers in the early 2000s was less well developed than it is now. Kerelaw had missed the deadline for registration of care workers with the Scottish Social Services Council. It was progressing and people were working towards registration. Care workers were meant to get a basic social care qualification. People were sent to get the qualification and gradually staff were becoming qualified. What was striking was that some people who had worked at Kerelaw for years were getting the qualification and then coming back

and behaving in exactly the same way as before. There appeared to be no evaluation of what individuals had learned from their training. As far as we could tell, it was not standard practice for a manager to sit down with an employee who had been on a training course to discuss what he or she had learned or how it would affect his or her practice.

85. Supervision of care workers was meant to be a kind of performance management discussion. As I recall, Glasgow City Council were introducing personal development plans around the time we were carrying out the Inquiry. The plans were about how employees could develop and what they could do to develop their practice. My own view is that there should have been a proper performance management system where people had aims, objectives and accountability. They could have had plenty of empowerment as to how to best to attain their objectives, but within the parameters set down by managers as to what was to be achieved.

86. If the substitute for that kind of performance management and appraisal in social work and care is supervision, then supervision needs to happen and it needs to take place regularly. If a care worker is supposed to have a meeting with their supervisor four times a year then they should have a meeting four times a year. There were some staff at Kerelaw who had not had a supervision discussion in years. Some people got it, some people did not. Senior management should have been telling line managers that it was part of their job description and that they would be held accountable if they didn't carry out supervision. There's less of an excuse for supervision falling behind in a residential setting where staff are there all the time compared with field workers who have to come in for discussions. In a place where staff are present, supervision should not be difficult to carry out effectively.

87. In terms of external management, there was a tendency for Kerelaw to be out of sight, out of mind. The City Council just didn't pay Kerelaw the attention that it should have. There was external management and reporting up to headquarters, but there seemed to be insufficient attention given to it. There were several external managers during the period we considered and there were differences amongst them. Some walked

around Kerelaw and spoke to young people when they visited. Others just came in and spoke to the Principal.

Support for children and social work input

88. If there had been no care planning for children, it would have been picked up by the inspectors. On paper, there did appear to be planning but within a context of things not working very well. Some of the culture at Kerelaw appeared to be reflected at Glasgow City Council. It came across to us that one senior social worker in the children and families department was trying get hold of things and draw attention to what was happening at Kerelaw, but that person was being badly treated by another senior manager and had a rough time. It was a complex and difficult dynamic.

Inspection reports

89. We were given access to the old inspection reports of Kerelaw and we were able to look at them. These included reports from Her Majesty's Inspector of Education (HMIE), the Social Work Inspection Agency (SWIA) and North Ayrshire Council. There were two streams of inspection, the schools inspections which inspected the education provision and the social work inspections which inspected the care provision. HMIE inspections didn't take place very often, but they would look at the provision of education in the open school and the secure unit. The social work inspectorate reports about Kerelaw were more critical. However, there was a lack of an overview of the inspections and it wasn't being provided by external management, which is to say Glasgow City Council.

90. In May 2008, I had a meeting with two senior people from HMIE who had been involved in the inspections of Kerelaw. I provided the team with a copy of my notes from that meeting. I took issue with HMIE because I thought the school inspection reports were rather complacent as they used the word 'fair' to describe the education provision. In my naivety I understood the word "fair" to mean broadly ok but I was corrected by one of the chief inspectors, who told me that 'fair' meant that there were deficiencies. When I asked them how they could have been submitting what seemed to be satisfactory

reports, they suggested that they weren't satisfactory and that they had been more critical of Kerelaw than I was giving them credit for. Nevertheless, I felt that the euphemisms that were used in HMIE reports at the time were not sufficiently to the point about what was wrong.

91. In the course of my meeting, the representatives of HMIE suggested that there was a need for a national organisation to consider what would be appropriate accommodation for a child on a case by case basis, working with Children's Panels to ensure that vulnerable children were not co-located with young offenders, and to get away from dependency on individual heads of schools and individual local authorities which can refuse to pay for placements. We didn't make a recommendation about that in our report. I think that HMIE were the only people who suggested it and we didn't pursue it. We considered it was a government policy issue and not within our remit.

92. After an inspection, the HMIE report would be submitted to the school Principal. The Principal was supposed to follow it up. There would then later be some follow up by the Inspectorate to check what had been done about their recommendations. Sometimes they were actioned and sometimes they weren't. I can't remember whether it was an education or social work report that, at one point, was passed on to headquarters in Glasgow by the Principal of Kerelaw without even a comment. One did not get the impression that the top management at Kerelaw were terribly impressed by the inspection reports that came to them. They didn't seem to me to be as interested in fixing things as they should have been. My impression was that they were often going through the motions. This seemed to be accepted by external management in Glasgow. What one would expect was that external management would follow up action on recommendations themselves. Sometimes they did and sometimes they didn't, but one did not get the impression that there was always a rigorous response to reports. That doesn't mean there was no follow up at all, but sometimes it fell short.

93. We thought that the North Ayrshire Council inspection reports were very thorough. They were more to the point. North Ayrshire kept on doing inspections of Kerelaw even after Glasgow City Council had assumed responsibility for the school. They did a broader inspection than HMIE. They would raise issues like the state of the building.

They would suggest that ripped furniture be replaced or walls be repainted, but it wouldn't just be about that. They did pick up on some things about the culture at the school and relationships between staff. Our team felt that the North Ayrshire Council reports came closest to suggesting that all was not right at Kerelaw.

94. I remember speaking to someone, who I think worked for the SWIA. It wasn't quoted in the report of the Independent Inquiry, but they said that it had all been smoke and mirrors at Kerelaw. They would go along and meet the senior management and get the usual senior management spiel about how good it all was. They were never absolutely convinced and they were beginning to become more critical towards the end of the period. I felt they had come closer to finding that all was not as it seemed than HMIE, whose remit was narrower.

95. In August 2004, a joint inspection of Kerelaw was carried out by HMIE and the Care Commission at the invitation of Glasgow City Council. Up until then, they had usually been separate. It raised concerns about Kerelaw, was very negative. and set alarm bells ringing. It accelerated the decision to close Kerelaw. The joint investigation picked up things that were not picked up by the previous inspection regime.

96. All the inspectors were supposed to engage with the children. I don't doubt that was done, but I don't know the details of how that was achieved, and some inspectors may have been more thorough than others. We felt that none of the inspection reports quite got it and that they hadn't really picked up on what they ought to have. The inspectors would stoutly rebut that, but they weren't uncovering matters that we were subsequently told about. There may have been reasons for that, not least that people probably weren't telling the inspectors.

97. Additionally, it appeared to me that HMIE reports were highly stylised. There were certain boxes to tick. My feeling was that if you have a template covering very specific things, you won't pick up on underlying cultural, attitudinal and behavioural issues. A template will pick up, for example, on whether progress by children towards, say, a Scottish Vocational Qualification was what it should be, and on pedagogical matters that schools inspectors wish to consider, but if it all gets put on a template, what about

other matters? I do think the education inspectors took the view that it wasn't for them to look into anything other than the quality of learning. They were looking for how well children's educational needs were catered for and at educational attainment. They weren't looking for issues with care workers, although it could be that the educational attainment of some children was poorer because of how they were treated by some care workers. However, how inspections were carried out and how they reported were determined by what HMIE's remit was at the time.

98. What was quite clear to the Inquiry team was that you shouldn't rely on inspections to get the culture right in an organisation or uncover things that managers do not want you to know about. It's no good assuming that because an institution is inspected, nothing can go wrong. It's simply not true and we felt that what happened at Kerelaw proved that. People should not take comfort simply from the fact that there is an inspection regime. I think inspections are a good way to encourage people to do what they should be doing, but they're not enough. Leadership from the very top and skilled and committed managers and staff are essential.

Complaints

99. There had been issues about the complaints system not working properly at Kerelaw. The procedure was clearly not being followed in all cases. Many children did not know that they could complain outside Kerelaw. A lot of children didn't know that they could go directly to their Children's Rights Officer. The complaints procedure was that children had to ask the manager of their unit for a complaints form. The people that they wanted to complain about were often the people in charge of the forms. According to staff, there was an impression among the children that nothing could get beyond the Principal. Children felt that there was no point in complaining because it would all just be dealt with internally. That was untrue, but the system did not function well.

100. I can't recall whether complaints were supposed to be passed to the Principal or what the process for complaints was. There were certainly supposed to be records kept. You would expect the unit manager to want to know what was going on in his or her unit and you would expect whatever record was kept in the units to be monitored by

the senior management team. I don't believe that the record-keeping would have been 100% accurate. Some children did complain. Some wanted to and were told that there was no point. Others were unable to get the form to complain. It simply didn't come. I don't think complaints were always responded to. The Children's Rights Officer from the Council used to go into Kerelaw. She received some oral complaints, but as a system the complaints procedure was not fit for purpose.

101. We didn't hear about any complaints being escalated to external bodies. Runaways were often being reported to the police. The police were apparently regularly called to Kerelaw because of children who absconded. There was one anecdote that we heard from several people about a young person who was assaulted by a member of staff while in the custody of the police. He or she was being brought back to Kerelaw and was allegedly struck by a care worker. The police were said to have got back in their car and driven away. If there was an assault the police should not have stood back. We weren't told about any follow-up when children ran away, either internally or externally. Some of the care workers are bound to have asked why, but I didn't get the feeling that there was huge interest in that. There were some children who ran away a lot and were labelled as absconders.

Council's handling of disciplinary matters and submission of names to the Disqualification from Working with Children List

102. As part of the Independent Inquiry, we also looked into how the Glasgow City Council handled the process of submitting names to the Disqualification from Working with Children List (DWCL). They didn't seem to do that very cleverly. People found themselves on that list when they believed that they were innocent and found it hard to challenge this. They couldn't get work while they remained on the list. The people administering the list couldn't do anything about this because they didn't have full information from the Council. They wanted to know whether a member of staff would have been dismissed or not as a result of any disciplinary action, and, if the answer was no, why the name had been sent to them. It was administration that didn't work as well as it might.

103. The dismissal of staff didn't work well either, including in the cases of the Principal and the Vice-Principal of the school. I think that more or less without exception staff who were dismissed won their Employment Tribunals. There were real deficiencies in the way that the Glasgow City Council had handled that. I suspect that was because of a need to respond quickly to political concerns within the Council.

104. There was a lot of unhappiness amongst former members of staff at Kerelaw about the manner in which the Council's investigations had been carried out. Those who had not been involved in abuse felt that they had been accused but had not been able to defend themselves. They felt that there had been a rush to judgement about them. There was a lot of resentment and hurt.

105. Some actions that did not necessarily justify the whole weight of a disciplinary process were pulled into it. In fact, minor and trivial matters could have been dealt with in a different way. It's a problem for many organisations if there is an immediate application of a disciplinary process to any mistake or misdemeanour. A lot of former Kerelaw staff felt oppressed by how the process was applied to them. It was unduly heavy-handed with regard to a number of people who didn't deserve heavy-handed treatment.

Conclusions and recommendations

106. In the course of the Inquiry, I think we did what the remit asked us to do. We looked at specifics as well as the headline issues. It became apparent quite early on that there was poor leadership, poor culture, poor external management, factionalism and lack of values. That is no great revelation.

107. I reported back to the Deputy Director at the Scottish Government during the Inquiry. From time to time, I would get phone calls asking when the report would be ready. I kept having to tell officials that we needed to take some time. That was the extent of Scottish Government involvement, and I was under no pressure as to findings. I think we did provide a draft of our report to the Scottish Government. They certainly didn't ask me to cut anything out or change anything. I'm not sure whether Glasgow City Council were given a draft, but we did give them the gist of where it was going. The

report of the Inquiry was our own and the Government and Council did not influence it in any way.

108. We presented our findings to Scottish Government Ministers and officials and the leader of Glasgow City Council. I have provided the Inquiry with a copy of my typed notes for the presentation. The leader, Stephen Purcell, said that the Council would do everything that we had suggested in the report. The Scottish Government said that it was fine. The date of that presentation was 20 March 2009. The report was sent for printing around that time. It was published in May 2009 after I returned from overseas. I did a press announcement to launch the report on 12 May.

109. The only conclusion we reached that differed from the investigation by Glasgow City Council was in respect of the figure of forty alleged abusers. We could not substantiate that forty people had been involved. We didn't reach a different conclusion on the basic allegations, that young people were being abused and a lot of staff, if not doing it, were complicit in it and not calling it out. We did feel that the case hadn't been made as to the number of staff deemed by the Council to have been involved in abuse.

110. The systemic issues we identified were: a lack of appropriate leadership from the senior team and the person in charge at Kerelaw; a lack of attention to what kind of organisation Glasgow City Council and those in charge at Kerelaw wanted to have, how they were going to get there, and what were the right values; recruitment of people which was not values-based and no reinforcement of values at induction; and a lack of willingness to address serious cultural issues. I think too that Kerelaw could have been more generously funded. That might have improved the ambience. There certainly were arguments about funding. The option of a new Kerelaw foundered so far as we could tell on the issue of who was going to pay for it. Funding and financial challenges were a big distraction generally in the Children and Families Department at Glasgow City Council following local government reorganisation. Staff numbers at Kerelaw were not a big issue that people brought to us, but I'd be surprised if it had all the staff it needed There were probably always vacancies that put everyone under pressure. If there had been no staff numbers issues it would have been very unusual for an organisation reliant on public funds.

111. We didn't want to come up with recommendations about changing legislation. If people had done their jobs properly and given proper attention to what was changing in the world of children in care, the problems might have been avoided. If they had been attuned to change, and how they and the organisational response needed to change then a lot of what took place would not have happened. There was a societal shift to people believing children if they said that they had been abused instead of people saying that it was impossible and it couldn't happen. That started to come about in the 1990s, which coincided with Kerelaw being orphaned following local government reorganisation. Reorganisation meant that people in local government had their eyes on different things, such as how they were going to run Glasgow City Council and who was going to get what money, rather than paying attention to an institution that wasn't keeping up with the times.

112. The formal launch of the report was the end of my involvement. I wasn't involved in the implementation of any of the recommendations. There wasn't much for the Scottish Government to do. The report was largely aimed at people who were responsible for running residential schools and secure units. We did recommend that the Scottish Government should develop a national mechanism to gather, collate and analyse the patterns of complaints and allegations originating in residential child care units. I don't know whether they've done that, but they probably said that they would. I didn't have any further meetings with representatives from Glasgow City Council after the publication of the report. I did get some informal feedback that they did implement some of the recommendations, but I don't know which.

Rossie Young People's Trust, Montrose, Angus

113. I currently sit on the Board of Governors at Rossie, having been appointed two years ago. We hold ten Board meetings every year. As governors, we are supposed to get regular reports on performance against the strategic/business plan. We do get reports which could perhaps be a little more focused on the plan as such. We're due to agree a new strategic/business plan. I shall be supporting the development of performance measures in the new strategic plan on which it is appropriate for the Board to focus. It

is not for the Board to involve itself in day-to-day operations, but we do get regular reports on the operational side without actually drawing us into management. Sometimes governors can find it difficult to resist being drawn into the operational side of things, which is not unusual, and there are clearly matters we ought to know about. We get reports on, for example, the number of incidents every month, and use of restraint. We're also informed about staffing numbers, such the number of vacancies and staff off sick. All of that is fine, but we are looking to make changes to presentation, which have been agreed, so that we have more information on trends, broken down by unit so far as possible: anything that enhances our ability to ask the right questions of management.

114. We also get financial reports about how much we are spending against budget. Budget management is challenging as financial pressures are considerable. It would be usual for there to be a key performance indicator for senior management that requires income and expenditure to be in balance at the end of the year. Throughout my career, I've always had that as a performance requirement as a budget holder.

115. We are given figures about complaints from young people, although I'm not sure when we last saw those. Again, it is helpful for these to be reported in a way that enables the Board to see monthly trends. If statistics can be broken down according to residential units, it is possible to see if for example there is one that is generating a lot of complaints or if they are evenly spread. Information of this kind is not itself the answer to problems, but it helps senior management and Boards ask the right questions. It can sometimes be a difficult message to get across to senior management that the more information of this kind is available the easier it is to ask the right questions. Some managers in organisations may feel concern about this, but I doubt that most Boards would regard an adverse figure or a target missed as by definition a failure. If there is a spike in incidents, for example, this can be due to one disruptive young person rather than a general problem. It is important for Boards to be able to understand that but also to ask about the reasons, and what action may be appropriate. There's a certainly a place for this kind of information being readily available to Boards in institutions like residential schools and secure units, difficult and complex though they are to manage.

116. An important point is that there is a Board comprising members who don't work in Rossie. Its members are volunteers, who have responsibilities as charity Trustees and cast external scrutiny on the senior management team. Some people have been on the Board for a number of years and come from the local area. There is a risk that if people serve too long on Boards that governance may suffer but I feel as a newcomer to it that the Board is discharging its duties correctly. We're certainly providing "external" supervision in a way that the local authority in Glasgow did not do at Kerelaw. Nevertheless, there is always room for improvement. A training day for the Board is scheduled for early in 2023.

117. I feel that as a general matter of governance people who have been on a Board for a long time should move on to allow for new blood. I'm at present the vice-chair of the Board and am supportive of attracting new blood, which we have been doing. It's a double-edged sword of course because when loyal volunteers step down, it can be difficult to replace them. Many good people do not want to be involved in a residential school and secure unit for what they may see as "difficult" young people. Also you're unlikely to get a Scotland-wide response from people who would need to travel to just outside Montrose for Board meetings. We have brought in new people who are relatively local to Rossie. I think they will add considerable value. When I joined two years ago two others joined at the same time. One has since resigned, and the other is still on the Board. Getting new blood and different perspectives is a good thing.

Accountability of senior management team to the Board

118. I am supportive of a formal accountability framework for the CEO and senior team, not because they are doing other than a good job, but because as indicated above the effective use of performance indicators is a key performance management tool. If the Board can see clearly the patterns of, for example, staff sickness absence, incidents, assaults by young people on other young people or by young people on staff are, it can look at setting targets for reducing the numbers, if necessary and feasible. It might not be possible easily to reduce the numbers, as much may depend on how damaged, disturbed and disruptive some young people at Rossie may be at a given time, but targets tend to focus the mind.

119. Proposals do get presented to the Board that we don't agree, so it is by no means a matter of rubber stamping.. We get a lot of information, but as I say there is always scope to make the performance framework more useful. For example, if we're saying that we want physical restraints through Crisis, Aggression, Limitation and Management (CALM) interventions to go down, which is our policy, then we need to be sure the management information enables us to know if we are doing that as well as it might.

120. Pay is a difficult issue for charities just now because of the cost of living crisis. Employees of small charities are not particularly well paid. We had a budgeted pay increase for 2022 that pre-dated the cost of living crisis. We have not been in a position to agree a further increase meantime as it would require us to use up financial reserves, or make paybill savings by cutting posts, which could affect our operations. This is a dilemma faced by voluntary and third sector organisations throughout Scotland.

Strategic planning

121. There was a strategic/business plan that ran from October 2020 until October 2022. It had something like 18 strategic priorities, 88 strategic objectives and 175 performance measures. These are rather unmanageable numbers, and a challenge for any CEO to keep tabs on, let alone the Board. We shall be discussing possible simplification and what we'll have by way of reporting on a new strategic plan, in due course.

122. A key responsibility of governors, Boards and trustees of all kinds is to sign off a strategic plan for the organisation and then monitor its performance. In my experience it can be helpful to involve Boards in drawing up the strategic plan at an early stage, or at least in giving a steer. I would expect the CEO and the senior team to put the plan together, but I believe that there is a case for Boards to be involved at an earlier stage, if only in a general sense. That's an area of governance at Rossie that I'd like to explore.

Culture at Rossie

123. The culture at Rossie is very different from Kerelaw. It is young person-centred with the emphasis on care and compassion. There is a focus on understanding trauma that the young people have had and taking a therapeutic approach to that. I can't provide examples of the therapeutic approach, but there are programmes that reflect it. The values are very much informed by the Scottish Government's "Promise". I believe that staff do embrace that approach. There is a values-based approach to recruitment. Induction focuses on the values of Rossie and the behaviours that are expected at Rossie. I have seen those behaviours in practice. It doesn't mean that no one inappropriate could slip through, but it's quite different from Kerelaw.

124. One of the things we are seeing is that some of the young people being sent by their local authority to go into residential care would really be more suitable for secure care because of their behaviours. A number of local authorities are sending us young people who are supposedly suitable for non-secure care when they may not be.

125. About a year ago, we had a youngster with considerable behavioural problems, who had been in secure care. That young person made progress at Rossie and with the agreement of his placing local authority, and on the basis of a risk assessment, the young person was able to move out of secure into residential care. Some time after that, they absconded from Rossie and assaulted an elderly. This was a big issue in the local area. The young person was prosecuted and given a custodial sentence. Questions arose as to whether they should not have moved out of secure care, but these are difficult decisions to take. Judgements of the kind that led to the young person moving out of secure are taken in prisons all the time, not least with longer term prisoners preparing for release. In such circumstances, a risk assessment is made, and the person may if appropriate be given the opportunity to be "tested" in the community, either on day release or a home visit. It cannot be absolutely guaranteed that one or two (and it is a very small number) will not betray the trust put in them and there is always criticism if any of them abscond. But as I say there are difficult judgements to make.

Oversight by governors

126. One way that the Board can oversee lived experience at Rossie is by walking round. There is a rota for governors and each governor is allocated a month in which to walk round. However, a governor can turn up at any time and do that. Because I'm travelling from Edinburgh, I am likely to do it in the afternoon when I'm at Rossie for a meeting anyway. Others closer at hand can just turn up. One governor who lives locally has arrived at 10:00 pm and stayed until 2:00 am. That is good practice.

127. There is the opportunity to speak to the children when walking round. It's not as easy as one might think because during the day young people are generally in a class or involved in some other activity. You can go in and sit in the class. The young people generally want to know who you are and what you are doing there. You gain an impression of relationships and of whether there is tension. Young people do from time to time kick off, but nobody has done that in front of me yet. I think evenings tend to be a common time for kicking off, when young people may not want to go to bed or have other issues.

128. There was a secure "fun day" at Rossie in the summer. I attended along with a number of fellow Board members. The young people in the secure unit were out in the enclosed area. It is quite a large area with grass and there were various games that they could play. The atmosphere was extremely good and positive. The interaction that I could see between the staff and the children was excellent. You could see a lot of mutual respect and good behaviour. One of the young people said it was the best day of their life, which was sad in a way. I think it's important that governors get involved in activities like that as best they can.

129. Rossie does have a learning and development strategy. The governors are able to see that. We get a report about learning and people are required to fulfil continuing professional development. I've asked around whether there is any evaluation of their training and I'm told that there is. As far as I know, staff are generally getting their formal "supervision" regularly. The Board is obviously interested in that. Clearly the

Board ought to know whether we're complying with our own policies and procedures in that regard.

Crisis, Aggression, Limitation and Management Physical Intervention (CALM)

130. At Rossie, a system known as CALM is used. Physical intervention is very much a last resort. The policy is to make it a last resort. Every incident, from swearing at a member of staff right through to physical interventions is recorded. I doubt the Board needs to know about low level incidents like swearing, but we would want to know about assaults, bullying and use of CALM, and any higher-level aggression. It is helpful to have information about when CALM has been required, presented as a time series, the better to understand trends. I am interested in whether numbers might be going up or down, and if so why. When there's an upward blip, it may be due to one very disturbed young person accounting for multiple recorded incidents.

131. According to the information that comes to the Board, there is a systematic approach to refresher training in CALM. That was not present at Kerelaw in respect of TCI. The committee that I sit on at Rossie was recently given a demonstration of CALM being carried out by a staff member on another member of staff. It was only a demonstration, but it was well done. The people involved explained how physical restraint was a last resort and that de-escalation was a key part of the CALM approach. That was reassuring. There is also quite a high ratio of instructors to staff at Rossie. The refresher training therefore shouldn't fall behind. I've still to check whether there is external input into the refresher training. I think that there is and I think that's a good idea.

132. Although training appears to be sufficient, I favour – as I have said already - regular trend figures for CALM interventions. It's one thing getting it every month and being told that numbers are down on the previous month, but it is important to have a time series. That's the sort of thing external managers and governors should be asking for.

133. There was a unique set of circumstances at Kerelaw because of local government reorganisation. There had been changes in society and people began to believe

children who said they had been abused. I would like to think that the abuse that took place at Kerelaw could not happen at Rossie, but one can never know for certain. You can ask questions and you can walk round and that's important to do, but whether that means it can never happen, frankly I don't know. There are good practices at Rossie that were not there at Kerelaw. The recruitment of staff and values are different. Regulation and inspection are different now. We contract with 'Who Cares? Scotland' to ensure there is external, independent advocacy and that complaints can be made. Can you stop abuse from ever happening? I don't know, but you can make it much less likely.

Hopes for Rossie's future

134. I would like to see us put some indicators together about outcomes for young people at Rossie, something that moves us on from measuring inputs. Recently, the Board of Governors was given a presentation about the number of young people who had obtained educational qualifications, whether it was a Scottish Vocational Qualification (SVQ) or a module or two. Much of the education is very basic and often children have previously fallen out of education. If outcomes are being considered, it is important to be realistic: with a focus on what might be attained consistent with the length of time that the young person is spending at Rossie. We could also usefully explore non-education outcomes. Can you turn a therapeutic intervention into an outcome? It's complicated and it may be very difficult to do, but I believe that Boards should raise questions about this and it should be discussed. Not everyone considers that feasible in an institution like Rossie. I understand the difficulties but as head of the SPS I had a range of performance targets to meet, and part of my salary depended on doing so. It's difficult, but we should try.

Final thoughts

135. It's far from easy to measure what works and what doesn't work in residential childcare settings. It partly depends on how long young people are there for. If someone who has no qualifications of any kind and manages to get a very basic SVQ 1 in the six

months that they're in Rossie is that good? I would say it was. I doubt anyone really knows what the longer-term outcomes are. The Scottish Government introduced the Promise following the Independent Care Review. What it says is great in terms of how we should care for looked after children. But it's mainly about inputs and has little if anything to say about outcomes for the young people themselves. There is sadly for too many a direct path from being in care and entry into the justice system, young offenders' institutions and then prison. One good outcome would be if children who had been in care didn't progress through the criminal justice system and end up in prison. But is that all dependent on six months at a Kerelaw or Rossie?

136. A similar question arises in relation to prisons and rehabilitation. What is the role of prisons in reducing reoffending compared with the role of other influences after release? How much "rehabilitation" can be achieved during an eighteen-month prison sentence of which nine months will be served? You may achieve useful results from programmes and interventions with those serving long term or life sentences, but it's more difficult to run effective programmes for those serving short sentences. There are some. SPS had some success with programmes for sex offenders, who were serving longer sentences. Consider drugs: is SPS being successful if prisoners stay off drugs or even reduce the harm of drugs by changing behaviours? Similarly, if young people in care with a history of self-harming stop doing so, might that be seen as a successful outcome? It's hard to pick your way through what might be regarded as successes. If there are successes, it could take some years before it is apparent that an ex-prisoner has managed to put their life together thanks to an intervention while in prison.

137. When it comes to the Promise, you can measure its success in terms of how organisations that are given the responsibility of caring for young people are behaving towards them and treating them. You can assess whether they are engaging young people in decisions about themselves, and whether young people feel safe etc. There is nothing I would criticise at all about the spirit of the Promise and what it aims to achieve in terms of how children are looked after. Rossie has spent about two years with a strategic plan that has been very focused on implementing the Promise.

138. What has the Scottish Government said about what the Promise should lead to? I do not know, other than that it doesn't really want young people to be in secure accommodation at all and is unhappy about cross-border residential placements from England. Once governments make an important policy announcement, it's easier to focus on the next announcement than to tackle the really difficult issue of long-term outcomes and evaluation. Somebody has to start thinking about what the policy is supposed to achieve in the longer term beyond the care experience and how it may be measured. To do this requires research tracking cohorts of young people after they leave care to find out what happens next. That's an expensive and very difficult thing to do.

139. I think that I think that we could do with attention being paid by policy makers to what outcomes are sought by the time the young people are ready to leave Rossie, and indeed in the longer term. Do interventions have a lasting effect? Does education fit them for more education or employment (depending on age)? Are they better able to cope with life after they move on? Are they better able to form healthy relationships with others? Can we prevent what is for too many a subsequent journey through the criminal justice system? We should try on all those fronts but there are no easy answers.

140. As to culture change in institutions - you can't just do it through a quick programme of training for staff. You have to take a lot of steps, and in particular you need leadership and clarity about what kind of organisation you want to have. You need consistency, clear service standards and constant repetition of what is the expected behaviour of staff. You must support that by having proper supervision and performance management. It takes hard work and a long time. Few politicians understand that and have unrealistic expectations of how long it can take. And of course, the "blame culture" which some perceive in public services, like the NHS, usually starts with them and trickles down the line.

141. How do we stop abuse from happening again? I think we can do our best. Listening to and believing children is important. I'm not sure legislation has made a lot of difference, but regulation and registration have. I believe better vetting of staff has been very

helpful. If you get that right you can hopefully avoid employing the sort of people who are likely to behave badly.

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

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

Dated..... 21 February 2023 .....