Scottish Child Abuse Inquiry

Witness Statement of

Ian MACFADYEN

Support person present: No

1. My name is Ian McRae MacFadyen. My date of birth is [redacted] 1957. My contact details are known to the Inquiry.

Background

2. Working with young people has been one of the main features throughout my career. When I began my career, I considered myself as a residential worker. When I qualified in the field of social work it was just before specialisms, such as children and families' teams, being developed. However, the caseload I carried would have more been weighted towards children and families. Albeit I was a generic worker and had a bit of everything, the senior social worker above me would have allocated me a higher proportion of teenage boys under supervision considering my prior experience and interest working in that field. I was fortunate enough to, at times, combine my experience of working in residential care with being a social worker in some of the roles I later took on in my career. Later on, I had the privilege of working for inspectorates inspecting establishments that provided care for young people both in England and Scotland.

Qualifications and significant training

3. I graduated with a BA in Sociology from Stirling University in 1979. Subsequently, I was a student on a post graduate career officer course at Paisley College of Technology, but I didn't complete the course. I left that course in around 1980. In 1984 I embarked on a two-year social work training course at Glasgow University. I

ultimately achieved a Certificate of Qualification in Social Work (CQSW) and a Postgraduate Diploma in Social Work in 1986. In 1992 I completed a MSc in Applied Social Research at Stirling University. My qualifications for working with children in residential settings would be included within my academic qualifications, which included both theoretical work and practice placements. The CQSW was designed to equip you to become a generic social worker.

4. I don't have additional certified qualifications, however, over the past thirty to forty years, I have undertaken numerous courses and training provided by local authorities, the third sector and central government. Some of that training would have been mandatory such as child protection training and equality and diversity training. That training was repeated every two or three years over the course of my career. One of the more significant examples of training I received is being part of the first cohort in Scotland to complete therapeutic crisis intervention training, which was one of the early forms of training surrounding restraint. We went to Milwaukee in America to receive that training. Over and above the training I have received, I have delivered bits and pieces of training over the years on topics such as child protection, working with staff in children's homes and children's rights.

Thornly Park School, Paisley, Renfrewshire

5. I visited Thornly Park on one occasion sometime in 1980. It would have been around that time because it had only recently closed to young people by the time of my visit. At that time, I was a student on a post graduate careers officer course at Paisley College of Technology. I visited Thornly Park with a fellow student from the course for one day. We had been asked as part of our course to organise placements or visits for ourselves that might be of interest. We decided we would like to visit Thornly Park because we felt it might be interesting. It must have featured on a list otherwise we wouldn't have known about it. Thornly Park was interesting because it was spoken about a lot and was regarded as quite a progressive and radical place. It was a place that fascinated me because of the stories that had preceded it. For a young person who was coming into the field of work I was being trained for, it was an appealing place for me to learn more about.

6. [GNG] [redacted] Thornly Park. He had been at Thornly Park since 1971. I didn't know it at the time of our visit, but [GNG] had previously been [SNR] at the Kibble, I think, between 1968 and 1971. I remember that when I was working at the Kibble, [GNG] was still being talked about. He was described by the staff at the Kibble as a very clever man. However, the way that it was put across to me was that he was almost too clever. His ideas were quite radical when put against the background of the Kibble.

7. The Kibble School was a traditional, reasonably strict, middle of the road establishment in comparison. Thornly Park was much more progressive than the Kibble with more thought put into meeting the individual needs of the young people who stayed there. It was maybe not as concerned about boundaries and discipline and therefore was regarded by staff at the Kibble as being 'too soft' or too liberal. I also heard from colleagues at the Kibble that there had been a serious fire at Thornly Park. It was thought that this might be attributable to the 'lax' approach to how the school was run. I don't know whether there was any truth in that.

8. We phoned up Thornly Park in advance and arranged to go and see [GNG] By the time we visited the school, it had been closed down and there were no children there. We met with [GNG] and a member of his, recently redundant, female staff members. I remember [GNG] talked rather wistfully about all the good things that had happened at the establishment. He talked about how they had been doing new and interesting things and how they had tried to work with young people in a different way.

9. Both [GNG] and the female staff member were full of sadness about the school closing. They seemed quite bitter about the way it had all been handled. [GNG] had lost his job and accommodation. He was talking openly about all of that in front of us and the female member of staff. There was this long story about how unfair it had been that the place had been closed. It was kind of a strange visit because, when we went out there, we didn't find what we expected. I couldn't really say anything more about my experience at Thornly Park beyond that.

10. When I did my social work training in 1984, GNG came and gave lectures about residential childcare. It was clear that he was a very well educated and well-informed professional. He spoke knowledgeably about the subject. I think it was then that I discovered that he had worked at the Tavistock Clinic in London. The Tavistock Clinic was a prestigious place that provided psychiatric care training. GNG was an interesting guy, was quite a significant person in the profession and someone who came with a strong reputation.

Lead up and recruitment process for the Kibble

11. In 1980 I was working as a salesman for Curry's. I wasn't very good at it and didn't really enjoy it. I was up at the Glasgow University careers office looking at the list of vacancies that was be displayed there. That was a fairly useful place for professional organisations of all sorts to advertise roles at that time. It was on that list that I discovered the vacancy for someone to work at the Kibble in Paisley. I'd just seen a film called 'Loneliness of the Long-Distance Runner', which was an old 1960s black and white 'new wave' movie about a working-class lad who ends up in borstal. The main character defies the system by throwing a long-distance race and the storyline fascinated me. That film came to my mind when I saw the advert for the role at the Kibble. I started to wonder whether the Kibble would be like the institution and the characters depicted in the film.

12. At the time of applying for the job, I had no demonstrable aptitude, experience, knowledge or anything beyond the fact that the role appealed to me. I thought that it might be interesting to work with the lads and that something constructive may come from that. The whole subject of working with young offenders then was current and topical. There was a lot of media attention, at that time, being paid to what were referred to as 'juvenile delinquents'. There were all sorts of ideas being discussed about intermediate treatment, alternatives to custody and how the problem could be resolved more generally. Jimmy Boyle was publishing his books and the Sunday magazines were full of pieces on how prisoners could be reformed. It seemed to be quite a trendy area to work within. I found all of that quite intriguing and there was a

bit of mystery about it. Added to that, the money was good. Looking back, I don't think I went into it with my eyes completely open. I wasn't fully informed or aware of what to expect.

13. There would have been three people who interviewed me. The chair of the interview panel was [redacted] John Turner was head of education and Clive McKnight was head of social work. I can't remember what questions I was asked. There would have been some sort of introduction or involvement with the boys. I remember being introduced to some of the boys in class and they asked me questions about myself.

14. There was a tour of the establishment. That would have been provided by John Turner. I can remember him telling me during the tour that they had made a couple of recent bad appointments which made my confidence grow. I heard that there was one employee who had had domestic difficulties who just went missing and they never saw him again. He left the school a bit high and dry. There was another employee, a young man called David Baker, who had been appointed in a similar role to me who, following appointment, was found to just not be suitable for the job and the boys were running rings around him. He didn't last very long. It didn't suit him and he didn't suit the school. That was as far as the interview process went.

15. There weren't really any pre-requisites for my employment. I suppose the fact that I had a degree in Sociology and that I came across as a reasonably engaging young man, who was interested and enthusiastic, might have led them to think that they might be able to do something with me. I don't know whether they perhaps thought that the way I presented myself might allow the boys to relate to me. I don't know what they would have done in terms of police checks or looking into my background. I can't remember there being any process surrounding that at all. Looking back, I suspect the vetting and screening in that respect wasn't, perhaps, as detailed and thorough as it could have been, but I expect there would have been some sort of due process.

16. I don't specifically recall having to provide references, however, I am almost certain that I would have had to because that was standard practice at the time. The

conversation I had with John Turner during the tour about the two recent appointments they had made that had gone wrong left me with the impression that they were taking particular care with their next series of appointments to run through their processes. If it was the case that I provided references they would have been from my current employer, Curry's. I think I would have also probably provided a written reference from someone at Paisley College of Technology. At the time, they would have been the two most obvious sources for references. If those were the references that I provided I think it would have been likely that they were followed up. The Kibble had made the effort to advertise the role in a bona fide location and appeared to be following some sort of due process, so I would be surprised if my references hadn't been followed up.

17. The role would have been explained to me at some point during my initial visit. I don't think there was a job description. However, I would have, as part of the tour provided by John Turner, been provided with an explanation of how the school worked. I probably would have been introduced to some of the staff who were carrying out similar tasks. I can't remember exactly who I spoke to, but I was given a clear idea of what the school would be like.

18. Looking back at the recruitment process, they probably were taking a bit of a chance with me. I think it was asking a lot of someone who was unqualified with no practical experience to come in and work with difficult young boys. I think the only way they could have determined whether candidates had the right attitude to work with children in secure care would have been at the interview stage. It wasn't the days when standardised forms of interviewing were used. A lot of it would have come down to personal instinct and judgement. That would be especially so where the candidate didn't have any qualifications. I think there had been quite a high staff turnover. People tended to move on quite quickly if their role didn't suit them. I don't remember there being a formal probation period but, at the same time, I don't remember paying too much attention to that.

Kibble Education and Care Centre, Paisley, Renfrewshire

19. I was at the Kibble for almost two years between approximately 1980 and 1982. I think my memories surrounding the Kibble are still quite fresh because it was my first real experience of working with children in residential care. It could also be because it was quite a challenging job.

Layout and structure of the Kibble

20. The Kibble was made up of two parts. The first part was what they called 'the old block school'. The old block school was an old Victorian ugly big building at the end of Greenock Road. It was smelly and just not a nice environment at all. My first impression of the old block school was that it was a grim foreboding place. It was a miserable looking building that was decaying and difficult to maintain. I remember that all the windows were painted battleship grey. Inside was pretty run down and there was a smell of urine in the dormitories. It was all pretty shoddy. Physically it wasn't a pleasant environment.

21. The old block school had locked doors that were kept closed. Although it wasn't a secure unit, there was a sense that the boys were to remain captive within the building and that they were expected to remain there. That was all done to prevent the boys from absconding. The doors would always be locked unless the boys were travelling to adjoining buildings or to the football pitch. Boys would be supervised when going to those places. Members of staff carried keys to make sure the doors remained locked. I remember one occasion when I foolishly lost my keys, which created a huge drama because it compromised the security of the establishment.

22. They were in the process of closing the old block school down and were planning to move the boys into another part of the Kibble during the time I was there. All of that was being pushed by SNR [redacted] GHK [redacted] He laid the foundations for all of that. The idea was that GHK [redacted] would retire, the old block school would no longer be used, and those boys would be absorbed into the new units. Clive McKnight, who was the deputy headmaster, took responsibility for implementing that move. The

move was going to be both a big administrative and cultural shift for the Kibble. I think the big idea behind this was that the Kibble would change from a discipline orientated environment or regime, where boys were controlled with locked doors and sometimes quite stern relationships, to an environment where the quality of relationships between staff and boys was how control was exercised.

23. The second, newer part of the Kibble was collectively known as 'the new units'. Those units were individually known as Mossway and Mossedge. The new units were going through the planning stages of being extended whilst I was at the Kibble. The new units were modern, low level and spacious. They weren't locked and had grounds around about them. It was a much more relaxed environment when compared to the old block school. They operated in a different way when it came to security. The outside doors weren't locked and there was more freedom for the boys to come and go.

Funding

24. Historically, the Kibble was set up by Miss Elizabeth Kibble who had donated money to the town. By the time I was there, the funding came in the form of a block grant from central government. In the early to mid-nineties, I heard there was a move away from funding being provided centrally to funding being provided more by regions. From what I heard that contractual change caused some difficulties with regards to capacity and resulted in the numbers of boys at the Kibble going down.

25. It was clear, by any objective measure, that the old block school building was inadequately funded. The conditions were well below par. As far as the boys' physical needs being met, the funding certainly wouldn't have been sufficient by current standards. If someone like Her Majesty's Inspectorate of Prisons (HMIP) had inspected the old school block using today's standards they probably would have closed it down because it was so bad.

General culture at the Kibble

26. I didn't have any serious concerns about the atmosphere and culture whilst I was at the Kibble. I wasn't really experienced enough to have an insight into what was going on. Ideas such as whistleblowing and children's rights weren't really concepts that existed at that time. I think, because of all of that, my expectations weren't particularly high.

27. The atmosphere was heavily male dominated and there was quite a strong pressure to conform. Control was a thing that was seen as very important amongst the staff. You needed to be able to show that you could control the boys. Failing to do so would result in you being seen as diminished in the eyes of your colleagues. That culture changed when we moved from the old block school to the new units. At that point, the emphasis shifted more towards exercising control through the quality of relationships. I think there was a period where both the staff and the boys found that shift difficult. It was such a big change, and it was unsettling for everybody. Things were quite difficult, morale amongst the staff went down and the level of absconding amongst the boys went up. I think amongst some staff there was a feeling that they were losing control and couldn't run the establishment in the way that they wanted to.

28. If I look back at the culture and atmosphere from the perspective of children's rights, even in the eighties, the Kibble wasn't good enough. It would have been regarded as rough and ready. I know that at some point before 1995 a guy called Graham Bell took over at the Kibble as headmaster. I heard that he did a superb job. I met Graham Bell in 1995 in Milwaukee in America at a conference about therapeutic crisis intervention. The conference had been designed for frontline managers of children's homes all over the world. There were about four or five hundred people in attendance at the conference. You got the opportunity to speak to colleagues who were doing very similar jobs to you. Graham Bell talked about what he was doing at that time at the Kibble. I remember that he was someone who was very financially astute. He came across as a very strong and effective leader. He sounded as if he was spot on in his thinking and had a clear idea about what he wanted to do. My impression as that he was just the sort of person you would want to run a place like the Kibble.

29. Graham Bell told me that there had been financial difficulties at the Kibble. He said that the change of contracts had meant that the number of boys there were going down. I think that the school was having some difficulty in maintaining their role and being able to develop their services. According to Graham Bell, he was in the process of helping professionalise and develop the services provided in the units. He was making massive changes to the training. He had built on the strengths that were already there and was modernising things. The way he described the Kibble was that it had become a properly functioning social enterprise with a high reputation.

30. When I was at the Kibble, there were limits to what we could do with the boys because quite often we were working with quite large numbers of boys at any one time. There wasn't much time available to spend with the boys an individual basis. There wasn't enough clear thinking about how the Kibble fitted in precisely with everything else. It was a time when things were changing and there was a recognition that residential care wasn't something that fitted everybody's needs. I didn't get the impression that there was a lot of clever strategic thinking going on higher up in the organisation. I think that change only really occurred when Graham Bell took over some time around 1995.

Role at the Kibble

31. My role was that of an unqualified residential childcare officer. I remained in that role throughout my time at the Kibble. The person I would report to was an experienced residential care officer called Jim Clark. I think he would have reported to Clive McKnight, who was the deputy headmaster, above him.

32. I didn't stay on site but lived in Paisley at the time. There were properties that the Kibble owned in Paisley that some of the staff stayed in. I remember that at one point I was offered a house, but I didn't take that offer up. For an unqualified person the money was good. You used to get what was called a Residential Duty Allowance. I think the salary was £5,600 a year plus other bits and pieces. That was good money

at that time for someone who was straight out of university. I think that was why some of the diehards amongst the staff remained there so long.

33. Residential care officers worked four days a week and one weekend in four. There were day shifts and back shifts. I remember that we worked a double shift on a Tuesday. Those shifts started at 8:00 am and finished at 11:00 pm. I don't know why there was a double shift. It was just the way that the shift pattern worked. I remember leaving work and walking to the train station after those shifts and always having a splitting headache. That happened every single time. I remember weekend shifts being quite onerous. The boys who hadn't been allowed to go home were naturally quite unhappy and could be quite difficult to work with.

34. Part of my job was to make sure that the boys' physical care needs were met. There was quite a lot of practical hands-on stuff. I would get the boys up in the morning, make sure that they got their breakfast, then get them off to school or the workshops. You would work out of the office when the boys were at school in the mornings then supervise and oversee lunch when the boys returned. If you were working in the evenings, after the boys had their tea, there would be a selection of different activities organised. That may entail football or taking the boys out to go swimming. I remember putting on quizzes and things like that. It was all stuff to keep them occupied during the evening. You would supervise supper in the evenings. We would take the orders and make sure that they were fed.

35. You could also describe what I did as doing basic casework. You would be liaising with the boy's family if there had been a crisis in the family. If there was anything that was going wrong, and the family needed help, our role would be to contact the boy's social worker to make sure they were aware of that. Every week I would go round and talk to the teachers and workshop instructors about how the boy had been doing that week. That information would be pulled together and fed back to the headmaster and his deputies for their Friday meetings. That input fed into the decision-making process surrounding whether the boy would be getting home leave that weekend or not.

36. The Kibble was a difficult and very stressful place to work in for several reasons. There were things that I could do with the boys because of my age and because I had the physical ability to do so. I think that was respected amongst the boys. I could get on quite well with most of them because of that. However, in terms of controlling big groups of boys, that wasn't a strength for me. A lot of the boys had more life experience than I had. They could at times run rings around the staff. That was a bit of a problem for me personally because, when some of my more experienced colleagues began recognising it as a problem, they started looking down on me.

Recruitment and qualifications of staff

37. I think the way other staff were recruited would have been similar to the way that I was recruited. I don't remember there being any big changes during my time at the Kibble. I suspect that those sorts of changes would have likely come in about the time Graham Bell was appointed headmaster in the mid-nineties.

38. The care that the staff provided at the Kibble was something more akin to a 'Cinderella service'. Some of the staff were unqualified and had limited agency when it came to decision making for the boys. I think the Kibble looked, ideally, to be recruiting people with experience and aptitude for working with young people rather than qualifications. Ideally, the Kibble would have preferred qualified people, but in practice they would have been looking for someone who was trained and had experience, however, even though the pay was relatively good at that time, the roles would have been difficult to fill. Those roles just weren't viewed as prestigious or providing as good opportunities as, for example, field work in social work.

39. When it comes to aptitude and personal qualities, they would have been looking for a few things. They would have been looking for resilience when working with young people. There was no escaping the fact that the boys could be quite difficult and could really put you through the run of the mill. That was especially so if you were a younger member of staff. At the same time they were looking for people who could demonstrate that they had something that they could bring to the table in terms of positive characteristics. They were looking for people who could be good role models

for the boys. They might be looking for people who had an interest or talent in music or sport. Those would have been things that would have been seen to make it easier to engage with the boys. Probably most importantly, they were looking for people who were morally sound. It wasn't referred to by the term then but they were looking for people who could show 'prosocial modelling'. Honesty and reliability were seen as important characteristics. Ideally, they would have been looking for people who had knowledge and experience of child development. However, in my particular case that was quite limited at that time. I probably only had a common-sense knowledge and understanding based on a relatively sheltered upbringing.

40. Grant Looker, who was appointed in a similar role to me at the same time, and I had no experience or qualifications before we joined the Kibble. However, there were members of staff who did. There were staff members who had come through routes on the care side. I remember three members of staff who had CQSWs. There were a couple of other staff members who had Certificates in Social Services (CSSs). CSSs were the pre-cursors to CQSWs. They were perhaps more vocational qualifications than academic ones. I remember one member of staff having a certificate from Langside College. Broadly speaking, the idea was that the younger unqualified staff would join for a couple of years then go on and do their training.

41. There were people who worked at the Kibble who went on to senior positions in the profession in later life. Ian Ross was someone who worked at the Kibble in the late sixties. He later became a director of Central Regional Council. I remember talking to him later in my career and recall him talking positively about GHK [redacted] There was another guy who was a night care worker called David Crawford. He went on to be the director of Strathclyde Regional Council.

Training and professional development

42. I don't remember there being any formal induction training. However, there was a form of mentoring and shadowing that took place. I remember Jim Clark taking myself and Grant Looker under his wing and showing us things. He helped us with things like showing us how to write a report and how to do various other things. That was done

informally but it was effective at the same time. I remember Jim Clark's input being useful. He had an aptitude for providing the training.

43. There was training provided throughout my time at the Kibble. There was a well-established set of training provided by The West of Scotland List D Training Group. I think that training was specifically designed for residential care officers. I was expected to attend the training, I think, every quarter. The training was developed on the English model where there was quite a well-developed psychology service linked to the approved school system. It was a group of psychologists who ran the training. They were impressive and were high quality people who knew their stuff.

44. The psychologists attached to the group would pull us together for training. It was only residential care officers who attended the training. There would be staff present from maybe three or four different List D establishments across Scotland. You would meet at a particular establishment and it would rotate. You would get a tour of the establishment and attend presentations, discussions and workshops. The topics would surround things like child development and challenging behaviour. It was pretty impressive and the quality of the debate and input was high.

45. I don't know whether the qualifications and training of the staff was sufficient to avoid the potential for abuse at the Kibble. Before any abuse can be treated it needs to be seen. I can say that the training wasn't good enough to form a clear view about where abuse might be taking place. That would probably be a fair comment to make about the standards of training that were in place at the time that I was there.

46. I remember that the teachers at the Kibble were self-contained when it came to professional development. I think that worked quite well for them. The availability of ongoing professional development for the residential care officers, whereas would have been limited. There wasn't a high expectation that you would do that. The quarterly meetings with the West of Scotland List D School Group were about as far as it went. I think the training met the expectations of everybody at that time when it came to professional development.

Staff structure

47. I'm not exactly sure how many staff members there were in total, but it would have been in the region of thirty-five or forty. There was a headmaster and two deputy heads, one in charge of education one in charge of social work. Below the deputies there were about four or five teachers, five or six workshop instructors, approximately ten childcare residential officers, four-night care officers, a matron, an assistant to the matron and half a dozen domestic staff. I think amongst those staff there were three who were professionally qualified social workers. The staff were predominantly male.

48. The workshop instructors were tradesmen who taught the boys various trades within the Kibble. They were all artisan working class men who had learnt a trade. The trades were things like bricklaying, electrics and painting and decorating. Those men were technically qualified in what they did, but beyond that a lot of them had good human qualities. A lot of the workshop instructors were able to build very good relationships with the children. They were just the sort of role models that the boys understood, wanted and needed and hadn't got elsewhere in their lives.

49. The Kibble employed specialist night shift staff to supervise boys throughout the night. They came on shift about 10:30 pm. They were quite a mixed bag. Some of them were very skilled, quite reassuring and soothing. However, that wasn't always the case.

Staff dynamics

50. Overall, the staff were generally sound, and I have broadly positive memories of them. There were a few different dynamics going on amongst the staff. There was a bit of tension between the teachers and the residential care workers because the teachers got paid more and worked less hours. There was also a tension between the older, more experienced staff and the newer younger staff. Without wanting to oversimplify things, the older staff tended to be stricter and clearer with boundaries. The younger staff, whereas, tended to be more relaxed in their interactions with the boys. There was a small number of people who weren't particularly committed or weren't

interested. The way those staff acted created a bit of tension. That tension isn't unusual in residential childcare, but it was quite heightened at the Kibble. Staff could feel under a lot of pressure amongst the boys, as this older age group could be very challenging.

51. It was easy to identify the really good staff members. GHK [redacted], SNR [redacted] was impressive. Some of the care staff were good. There were some members of the staff that I personally didn't get on all that well with. Those were the staff members who regarded me as a 'softy', who didn't really know what he was doing. On reflection, I think that reflected poorly on those staff members. They were a lot more experienced than I was and they should have helped, coached and supported me, however, they didn't. Looking back, I do think question the quality of the relationships that those staff members had with the boys themselves. I wouldn't categorise those relationships in the brackets of abuse or neglect, but I do wonder whether they were problematic.

52. I don't think the faults I encountered amongst the staff I didn't get on with were recognised by the management at the Kibble. I think the reason behind that was because the culture wouldn't have allowed somebody like me to easily speak up about something like that. That did lead to tensions amongst staff members. I remember there was a staff member called Stuart Connell, who was a unit leader in charge of one of the new units, that I didn't get on with. He was older, more experienced and didn't like the way that I approached things.

53. I remember an incident concerning Stuart Connell when I was working a shift in the new units. The [redacted] to a house where Stuart Connell lived. I was in the kitchen that evening and talking with one of the boys. I was surrounded by quite a lot of boys. We were having chit chat and banter and there was some sort of disrespectful comment made by one of the boys towards me. I can't remember exactly what was said. Stuart Connell overheard the comment and, rather than raising it with me, went straight to Clive McKnight who was the deputy headmaster. Stuart Connell complained that I had been unprofessional in my conversations with the boys.

54. The way Stuart Connell had raised his thoughts created tension between us. That tension must have come out somehow. I can't remember in what way that came out but, ultimately, there was an attempt made by one of the teachers to mediate between Stuart Connell and me. I think the teacher intervened off his own back. I believe Clive McKnight had been asked to get involved but he declined. Unfortunately, the intervention didn't work and the tension between me and Stuart Connell continued. It was a difficult situation for me because, albeit I was quite highly thought of, I was young and inexperienced. I felt as if I was being undermined by this older more senior member of staff. Looking back, my ongoing tension with Stuart Connell was an example of the lack of maturity in the organisation, the culture and some of the staff. A senior member of staff, such as Stuart Connell, shouldn't have been allowed to act in the way he did. Culturally, the place wasn't somewhere where I would have had a safe place to go to express grievances or raise concerns.

Staff

55. GHK [redacted] was SNR [redacted] He lived in a house [redacted]. He had been there a very long time. He had previously gone to Paisley Grammar School before serving in the second world war. I believe he was awarded a Military Cross during his service. [redacted] ran a List D school in Aberdeen before being transferred to the Kibble. GHK [redacted] started teaching in the Kibble after he got his MA in English Literature from Glasgow University. GHK [redacted] SNR [redacted] [redacted]. He was quite a charismatic, enlightened and well-informed individual. I would say he instilled an equal measure of fear and respect amongst the staff and the boys. He was a compassionate man. He took a very hands-on approach [redacted] I remember that he would come down wearing his vest and serve food to the boys. He was referred to by the boys as SNR [redacted]

56. I have latterly discovered that GHK [redacted] was highly regarded by the Scottish Office and, in particular, the Scottish Home and Health department, and Social Work Services Group (SWSG). He did a lot of strategic as well as operational stuff. He was a prudent manager of public finances SNR [redacted]. He would represent them from time to time. He laid the foundations for a lot of things

that later happened in residential care in Scotland. He is a guy who should have been honoured for the work that he did. He did a lot for residential childcare in Scotland.

57. Clive McKnight was one of the two deputy headmasters. He oversaw the operational side of things at the Kibble and managed the senior residential workers. He oversaw the move from the old block school to the new units. He oversaw that process, but the foundations had been laid by [redacted] when he was there. Following [redacted] retirement, Clive McKnight [redacted]. That was around the time that the old part of the Kibble was closed.

58. John Turner was head of education and deputy headmaster. He had formerly been the head of English at Lossiemouth Academy. He was a well-educated, extremely confident man. He was quite firm and traditional in his approach.

59. Bill Miller took over as head of education at the Kibble in late 1981 when John Turner retired.

60. Jim Louden was a residential childcare officer in the old school block. I don't think he was senior but he was very experienced. He had previously been in the British Army and seen action in, I think, Borneo. He was a particularly nice, grandfather-like figure and was a big avuncular, friendly and warm man. He was a very imposing man but he was an absolute gentleman and the boys loved him. He had tremendously strong qualities with all the sorts of things you would want from someone who works with young people. Everybody responded to him really well. He was well selected in his role as the staff member to welcome boys into the establishment.

61. Jim Clark was an experienced qualified residential care officer. He was head of the unit I was in, dormitory two. He was something like a team leader. He was who I would report to in my role.

62. Bill Armstrong was an experienced qualified residential care officer who ran another one of the dorms in the old block school. He worked with the younger group of boys at the Kibble. He was an older, mild-mannered man. He was an absolute gentleman

and was one of these warm grandfather figure types. He was very gentle and assured in his approach.

63. Paul Styles was a more senior residential care officer who oversaw another dorm. I think he had done some form of training down in England. He was English and was slightly eccentric. He worked with the youngest group of boys at the Kibble. His approach was more liberal and he was highly rated by the headmaster.

64. Stuart Connell was initially a residential childcare officer but he was later promoted to being a unit or team leader. He was more senior and had quite a lot of influence in the school. He worked in one of the new units, Mossedge, and lived in a house attached to the unit. He'd previously worked for the electricity board. He was from Ayrshire. He would have maybe been in his early fifties when I was at the Kibble. He always wore a smart suit and was immaculately dressed. I think he may have done the Langside College course surrounding residential care.

65. Grant Looker was appointed to be a residential care officer at the same time as me. Like myself, he didn't have any relevant training or experience at the time of his appointment.

66. Boyd McNicol was the Art teacher. He was a trendy hippy looking guy. I remember him doing fantastic things with the boys. Other teachers I remember included Sandy Cunningham and Danny McCrory, who worked closely together and were very good colleagues.

67. Joe was an established night officer who worked in the old school building. His nickname was 'Banjo' but I don't remember his surname. He'd worked at the Kibble longer than I had and been there for quite a few years. I think he was more used as a backup person in his role. I don't think he was the first choice but he was there quite a bit. He was older than me, possibly in his mid to late thirties. He was small and possibly between five foot four or five foot five inches tall. He was grey haired, slightly balding, clean shaven and quite heavy. I can't remember whether he wore glasses.

Children

68. It was all boys. They were all maturing teenagers. I would say that the age range was mainly between the ages of fourteen and sixteen years old. It was a senior school, so we didn't have really young boys. The numbers of boys at the Kibble were starting to go down during the time I was there. There were between fifty and sixty boys who were residential in the old block school. They were split across the four dorms broadly along the lines of age and maturity. There would have been between twenty and forty boys residential in the new units. I would say there was a maximum of between eighty and ninety residential boys at the Kibble at any one time. There were a small number of day boys. I think there were about twelve on the books. There were three or four boys that I had keyworker responsibility for.

69. We knew about the backgrounds of the boys from reports that were kept in files in the office but also through anecdotal comments between the staff. There wasn't the same sense of confidentiality and data protection that we have now. I think we all had a reasonably good idea of the things we needed to know about. There undoubtedly would have been lots of stuff that hadn't been recorded or the boy hadn't said anything about. That meant that there may have been things that were useful that we wouldn't know about. Looking back, we knew a fair amount but, inevitably, there was an absence of really good quality data available surrounding the boys' backgrounds to help you make good decisions all the time.

70. I don't think there was anything specific as to how and why certain boys were sent to the Kibble, although there was normally some sort of 'offending' involved. I don't think the establishment had a particular speciality. I'm sure there would have been something in the contract about the geographical areas that the boys came to the Kibble from. The boys would mostly be from the West of Scotland and mostly from the Glasgow area.

71. Most of the boys would have previously been in front of children's panels and under section 44(1)(b) orders under the Social Work (Scotland) Act 1968. Some will have been under section 413 orders under the Criminal Procedure (Scotland) Act 1975

which was a sheriff court order at that time. The boys who were under section 413 orders had generally committed more serious offences. I remember those boys having a bit more kudos amongst the boys and the staff. The nature of the offences was more dramatic, and the boys and staff would talk about that sort of thing. I think the staff understood the significance of section 413 orders and understood that those boys needed to be dealt with rapidly, quickly and effectively if they stepped out of line. That was different to the boys under section 44(1)(b) orders who were generally kept on a looser string.

72. I think the boys who were under section 413 orders tended to be older and stayed at the Kibble longer. They'd maybe go on to another establishment after staying with us. The boys who came through the children's hearing system were at the Kibble more based on need and their particular circumstances. That meant there was a variety of lengths of stay. With those boys, you had the capacity to involve social workers depending on whether you felt the boy needed to stay for a longer or shorter period. You could go to a hearing and produce reports about how the boy was progressing.

73. I think, like many establishments of that type at that time, there was a thought amongst staff that the Kibble was allocated all the most tough and complex boys. I remember staff members at the Kibble thinking that a bit. List D was just an administrative category which had come from the Scottish Education Department. There were also List G schools which were designed for, as they would describe them then, 'maladjusted children.' They were children who weren't involved in offending but, for various reasons, their behaviour was viewed as disturbed.

74. I think when researchers investigated the comparisons between the two different populations, there wasn't much difference and there were a lot of crossovers. I can't exactly specify what the research was called that made that finding. I remember the research focussing on gatekeeping at particular establishments. The research may have been in connection with the period of time when there was local authority reorganisation in, I think, in the mid-nineties. It would have been around the time when the council funding models were changing and they were concentrating on value for money exercises.

75. I think the research also found that where local authorities had a List G school, List D school or secure establishment they would use any of those types of establishments interchangeably, rather than sending the child to an establishment outwith their area, which could be very costly. They found that the placement of the young person was being determined by the establishment's location rather than the need of the individual. In particular, the research highlighted instances where children were being placed in secure care not on the basis of need, but on availability and geographical location. I think that was what the research I recall highlighted. I can't remember who undertook the research but it was definitely a thought I remember picking up upon at that time and found interesting. I think it would have been a piece of nationwide Scottish research rather than anything else. The List D and List G categories were Scottish ones and I don't think they went wider than that.

Relationship between the staff and boys

76. The workshop instructors held a really important role in the lives of the boys at the Kibble. I would say that the relationship between the workshop instructors and the boys was pretty good. There was a lot of positive stuff going on there when it came to their relationships with the boys. They were very positive role models. They were quite strict with the boys, but the boys respected and admired them. They were something like father figures to the boys. Working together they were able to provide the boys with guidance, advice and help them with things in a way that a young guy like me sitting across the table from a boy couldn't. I wouldn't have been able to communicate in the same way. Certainly, the quality of the relationship would have been different.

77. I remember a couple of the teachers being very impressive. A couple of teachers did team teaching together, working with one larger class at the same time. They were young, enthusiastic and had good relationships with the residential care officers. I remember one of those teachers coming to me to ask whether a boy, who was a day boy, could come out of class so that he could change his shirt. The boy hadn't had a shower for weeks and the teacher wanted me to discreetly help him. That was the

sort of thing that made me think that the teachers wanted to be working as a team. They were thinking about the whole needs of the young person rather than just their educational needs.

78. I know there is a Facebook website for old boys of Ballikinrain where the relationship between staff and former residents is discussed. I don't know whether there is something similar for the Kibble. However, I think if you were to speak to people in their fifties and sixties, who would have been in the Kibble in the seventies and eighties, the things they would remember were the workshop instructors.

Admission process for boys at the Kibble

79. I remember being involved with one boy being admitted. The boy's name was [redacted]. The boy's mother had taken him in to meet [redacted] GHK [redacted] SNR and myself. It was intended that I would become [redacted] key worker. [redacted] was really upset after his mother left. [redacted] GHK spoke to [redacted] in a very clear, reassuring, way about what was going to be happening. I was then asked to take [redacted] to meet Jim Louden, who was a senior residential care officer. He was the staff member appointed the role of giving boys a tour upon arrival at the Kibble. Jim Louden was well suited to that role.

80. I saw that Jim Louden put [redacted] at ease when I took him down. He kind of made a joke of it and it was all done with humour. He had some banter and helped the boy to relax. Jim made it ok for him. [redacted] was introduced to the boys during the tour. I don't know how that was done but it would have been done with some sensitivity. A decision was made at some point about what dorm [redacted] would have been going into. After [redacted] was given the tour, he would have been taken down to Jim Louden's office to be issued his kit. Jim Louden's office doubled up as the storeroom. I can't remember anything further about [redacted] admission or what happened more generally when admitting boys to the Kibble

81. Looking back, the admissions process was all rough and ready. You would pay much more attention to admission nowadays. You would more appreciate the importance

of first impressions. All that said, I wouldn't say what the Kibble had in place was terrible. Jim Louden was well appointed in the role he had.

Daily routine

82. I can't remember what time the boys were got up. It could be that the night staff were perhaps the staff members who got the boys up. I think the residential care officers came on shift for day shifts at 8:00 am so it could well have been before then. After getting up, we would make sure that the boys had their breakfast. After breakfast, the boys would congregate in the main hall.

83. There then followed a period where the boys would mingle in the old school hall. That period could be quite tense. All these teenage boys were meeting again after the day before. If there were fights or conflicts between them the previous day, they would have been seeing each other for the first time since that happened. That could be quite tricky to manage. What we used to do to distract the boys was to play a couple of games. Fortunately, I was quite good at those games. One of the games would involve kicking a ball at skittles that had been placed at either ends of the hall. If you knocked the skittle down that person was out and the next person would come up. That game was popular with the boys.

84. The other game was 'lethal' and called 'in for out'. The member of staff would have a football and stand in the middle of the hall with a circle of boys around them. The staff member would throw the ball to a boy, and they would return it back to you. If the boy dropped the ball, they would have to go out. If the boy was out and he refused to go out, immediately there was a confrontation created between you and the boy in front of the whole school, which could easily escalate. That could be quite mortifying so there were very few of the staff who would play that game. I think, because I was good at the game and happy to play it, I managed to get some kudos from the other staff members. It allowed me to bank some brownie points that I had perhaps lost elsewhere.

85. After we played those games, the boys would stand round the sides of the hall before the boys from the new units would come in. By 9:00 am either the headmaster or deputy headmaster would call out the classes and workshops. The boys would then go off to their classes or workshops. Most boys would be occupied in that way. It would be very unusual for boys to be left in their dorms. The boy would have to be really sick to be doing that. Boys would come back for their lunch at lunchtime after the morning classes and workshops. That would be supervised by the care staff.

86. At about 13:00 pm the boys would go through the same process again and congregate in the big hall. The boys would be allocated their workshops and classes and go off for those in the afternoon before coming back for their tea. The staff would have their tea separately in the staff room. I remember the staff teatime being organised by the matron and was quite a ritualistic thing for the staff. It was like a high tea. After tea we would all reconvene in the big hall and either the headmaster, deputy headmaster or the head of education would speak. That staff member would be on duty as the most senior person overseeing things that evening. They would explain what was available to do in the evening and the boys would choose what they wanted to do.

87. The boys would do whatever activity they had selected until about 8:00 pm when they would return to their dorms. They would then watch a bit of television in their dorms whilst they were served their supper. The boys would go off to bed between 9:30 pm and 10:00 pm. They were played music whilst they went off to sleep. The night care staff would come in and take over at about 10:30 pm. I remember it being quite satisfying and challenging to get through a shift and my adrenaline would be running high at the end. It was physically and mentally exhausting. It was a hard job to do.

88. On average there were five or six boys who would stay at weekends. It would have been quite a big management decision to hold onto more boys than that. You'd have to be confident about holding a lot of boys back because there was only a skeleton staff present. Weekends would be quite different to weekdays. They would generally be languid with not an awful lot going on. There was no prescribed daily routine. It was fluid, down to the staff members who were on shift and down to how many boys

were there. There may be a trip out to the swimming pool or Loch Lomond if the boys behaved themselves.

89. The weekends were perhaps where you would most see the differences in approaches between older and younger staff members. There could be quite different approaches depending on who was running the weekend. Some staff member's weekends would be more structured where others would be laxer. I can remember one member of staff would take cigarettes in so that he could use them as an incentive for things. That would have been very much frowned upon were another staff member to be on. I remember that there was a balance to be struck about what time to get the boys up and when they should go to bed at night. There were no set times, and it was down to the staff member on duty. If the staff member on day shift let the boys sleep in too late, the boys would be livelier and more energetic the subsequent evening. I remember that there was quite a lot of tension across staff on the different shifts surrounding that.

Mealtimes

90. The residential care staff supervised the boys' mealtimes but ate separately from the boys in the old block school. I remember teatime being quite a ritualistic thing amongst the staff. The staff ate their meals with the boys in the open unit. That was introduced during my time there. I think that had quite a civilising effect on mealtimes.

91. The food the boys was served was all pretty basic. The boys would joke about one dish that was quite popular. They nicknamed it 'cat pie'. It was like a cheap luncheon meat with pastry on top and the boys loved it. I remember that as part of the boys' supper they were given a rough and ready bun alongside small circular capsules with soup inside them. It was very, cheap processed dried soup. The boys quite liked them and they liked being given the opportunity to choose what they wanted. Looking back, the food was ok. We didn't get many complaints about its quality, however, the boys didn't expect very much.

Sleeping arrangements

92. There were four dormitories in the old block school numbered one through four. I worked in dormitory two. The boys were divided between the dorms, broadly speaking, along the lines of age and maturity. There could be as many as twenty-six boys in each dorm, although they were not always full.

93. The sleeping arrangements in the dorms were primitive. The windows were made from some form of thick plastic that had been strengthened. Those windows were deteriorating and had holes and scratches on them. The boys would have some posters up but very little of their space would be personalised. There were screens between the beds that were made from a cheap plastic material.

94. There was a damp, musky, urine smell which permeated through all the dorms. Bed-wetting was quite a predominant feature at the Kibble. It was just something that happened. It was managed in a no-nonsense manner. Boys would be told to grab hold of their sheets and laundry to take it to get washed. There weren't really any attempts made to protect the boy's dignity. It wasn't handled brilliantly but I wouldn't say it was handled terribly. It was regarded by the staff as a bit of extra work. It was all low key and matter of fact.

95. The work practices surrounding bed-wetting weren't intended to overtly stigmatise the boys who wet their beds. We were working with young people who were sleeping in dormitories. To do things in any other way other than the way it was handled would have been difficult because of the layout of the building. However, I appreciate that it could be seen as stigmatising. Staff did regard bed-wetting as a bit of an inconvenience overall. In hindsight, it could have been dealt with more sensitively. It wasn't great but, at the same time, it wasn't absolutely appalling. Although from the outside looking in it might appear a pretty awful way to treat children, I don't think that the boys were too bothered about it. I can't remember those boys who wet their beds being subjected to ridicule or bullying.

96. The Kibble employed specialist night shift staff to supervise boys throughout the night. They came on shift about 10:30 pm. They were a mixed bag. Some of them were very skilled, quite reassuring and soothing. However, that wasn't always the case. I remember one guy who was a nightwatchman in the old school block who was quite confrontational. I remember him winding the boys up and that led to it being difficult to settle them down. His first name was Joe and his nickname was 'Banjo' but I don't remember his surname.

97. There weren't any boys who made disclosures to me about Joe's behaviour. I think they wouldn't have regarded him as a formidable opponent. They would have been disparaging about him but I don't think they were scared of him. They more sort of disrespected him than anything else. I can remember colleagues talking about Joe in a fairly negative way. However, I don't think I was in a position to raise concerns. I was the most junior member of staff in the school. It wouldn't have been my place to comment on someone who had been there a lot longer than I had.

Washing and bathing

98. The toilets weren't particularly clean or hygienic and were all communal in the old block school. The showering facilities consisted of an open area. Boys were expected to shower naked in front of each other half a dozen at a time. There would be a member of staff present who would hold a stick to poke the ventilator to make sure steam would be getting out of the room. Visibility was not good and I remember that, if you turned your back, the boys would throw bars of soap at you. All sorts of mayhem and chaos might ensue amongst the boys. There was absolutely no sense of privacy or dignity whatsoever. Neither the staff nor the boys questioned the setup.

Leisure time

99. Leisure time was well organised and supervised. If you were working in the evenings, after the boys had their tea, there would be a selection of different activities organised. That may entail football or putting on quizzes. It was all stuff to keep them occupied during the evening. There was a television in each dorm that they would sit in front of and watch things like 'Hill Street Blues' and 'Little House on the Prairie'.

Trips and holidays

100. We had access to a van that we could use for trips. We would regularly go to the Victory Baths in Renfrew with the boys. Inevitably, one of the boys would get thrown out of the baths after about half an hour due to their bad behaviour. I can remember attempting to take a couple of boys to the cinema in Paisley but that was a disaster. At the time I attributed all of that down to just bad behaviour. Looking back, it was all probably often related to their spectrum disorders. They couldn't cope with external stimulation and things like that.

101. There was a favourite place in Loch Lomond where we would take boys at weekends. We would take a minibus of lads to pools on the loch that they could dive into and go swimming. I heard that, in times gone by, the whole school would go camping at a well-established campsite near Dunure in Ayrshire. Virtually the whole school would decamp and go there for a holiday during the summer. That had all stopped by the time I arrived. I don't remember there being any overnight trips during my time there. I think the much more valuable trip for the boys was to just get home on leave at the weekends. All the boys were desperate to get home irrespective of what the conditions were like there. It was always seen as better than remaining at the Kibble.

Smoking / glue sniffing / drugs

102. Tobacco was quite a currency in the Kibble. Most of the boys were smokers. We would get consent forms from the boys' parents if they wanted to smoke. I can't remember situations where consent wasn't provided. Not allowing boys to smoke probably would have caused too much hassle for everybody. Outside the main hall was a stone corridor. Three times a day we would issue those boys who were smokers with a cigarette there. Twenty or thirty of them would be sitting there having a fag. I remember that there was that much smoke you couldn't see a thing. There were no thoughts of any health precautions whatsoever.

103. Glue sniffing was a big outlet for a lot of the boys. It was prolific and some of the boys had a huge problem with it. Boys would abscond specifically to sniff glue. They would

buy industrial sized pots of evo stick and stash it in bushes in outside areas. When the boys absconded, quite often in a group, they would congregate together and sniff the glue. Those were almost like social events for them. I remember hearing that they would put plastic shopping bags over their heads to enhance the effect. I remember that those boys who abused solvents would cough up solidified solvent from their lungs and smear it on the screens by their beds.

104. I don't remember there being any structured organised support for solvent abuse apart from maybe a referral to a GP if there were physical symptoms. I can vaguely remember a couple of cases where there were medical people involved to try and help young people who were particularly bad. However, for routine cases there wasn't a programme or a particular approach. Staff didn't really have specialised knowledge or understanding about what advice or guidance should be given. Looking back, solvent abuse was something that we were very aware of but didn't have the confidence to tackle.

105. The boys weren't punished for using solvents. The staff more disapproved along a counselling sort of line. They would say things like "this could be really dangerous." I do remember that we had a visit from researchers from one of the local universities. They were interested in finding out more about the problem. I can't remember exactly what they said but I do remember them giving some controversial advice. They said something unusual and interesting to both the staff and the boys. I think that advice might have been that, in their opinion, the boys were better off with alcohol or something else rather than abusing solvents. The researchers spoke both with the boys and the staff but I can't remember anything further coming as a result of it.

106. I don't remember there being a serious issue with drugs on the premises at the school. I remember cannabis being considered very exotic and cool by the boys though. Bob Marley was venerated because he was an anti-establishment figure. They liked his attitude, loved listening to his music and enjoyed what they thought his lifestyle represented. However, I don't ever remember smelling cannabis on site and don't remember seeing it. There may have been pills taken outside the school but I don't

remember that, or any other drug, featuring prominently. I think alcohol would likely be the more common thing that boys got involved with outside of the school.

Clothing / uniform

107. There was kind of a uniform. The boys were required to wear clothing that was issued to them. The boys were allowed to wear their own clothes if they were going home for the weekend or when they were receiving visits at the home if they were remaining there over weekends. Jim Louden would issue clothing to boys on their first day at the establishment. I remember that part of the kit was underwear. The underwear would have three or four names and numbers scored out on them from when they had been issued to other boys previously. That was regarded as common practice and wasn't questioned too much. When I think back to all of that it must have been stigmatising. We didn't think that at the time though.

Schooling

108. Most of the education was provided by teachers on site. There were some boys who were able and did Highers and at least one attended an outside school. I vaguely remember some talk of linking up those boys with colleges. Every boy was expected to either go to classes or to the workshops during the day. The routine and compliance when it came to the workshops and classes was a measure of the subtle controls that were being used at the Kibble. Some of the classes and workshops were popular and the boys generally liked going to those things.

109. The teachers reported to the head of education. They were all qualified teachers and were all Education Institute of Scotland (EIS) members. I think that having a well-functioning education department was one of the strengths of the Kibble. A lot of the boys had previously had either a very limited education or had stopped attending education all together. What they got at the Kibble was small group education. The boys were getting a far stronger education than what they would have been receiving had they remained in their communities.

110. A lot of the teachers were of a high calibre. I recall being quite impressed with the teaching that was there. There were two young teachers called Sandy Cunningham and Danny McCrory who were friends of mine. They were a bit older than me and played football with me. They came across as being enthusiastic and committed. I remember that they used to 'team teach' which was a new idea in those days. They had good relationships with the boys and were clear in their boundaries. They always appeared to be interested when I would approach them for reports about how particular boys had been during the week.

111. There was a female teacher, Pat Young, who taught more of the boys who had emotional difficulties. There was a different atmosphere within her classroom. The atmosphere was quite reassuring, relaxed and a bit slower paced. She seemed to me to be a very effective teacher. There were a couple of the other teachers who I thought were ok. I always got the impression that the teaching staff were a professional unit who functioned well. They seemed to be quite self-sufficient. They were paid more and didn't have the same cares and moans that the care staff had surrounding conditions of service.

112. There was a more vocational education provided in the workshops but as far as the boys being educated in things like cooking, shopping, personal hygiene and paying bills, there wasn't much education being offered. The boys were quite institutionalised and there was quite a dependency created. Looking back, there were missed opportunities for those kinds of initiatives.

Healthcare

113. The matron role was more of a domestic rather than a healthcare role. She oversaw the laundry and the other domestic staff. The matron's assistant wasn't a qualified healthcare worker but was, I think, qualified in first aid. I don't think she was a nurse. If a boy had a high temperature, a headache or something minor they could be put in a little alcove that was known as the 'healthcare unit.' It was like a little pod or a small, converted room with a bed. If boys were under the weather or ill, they would go in there for a short period of time. I can hardly remember any boys getting ill or having

accidents at all. I can't remember ever seeing a doctor coming in or the boys receiving regular health checks. Were there to be the need, boys would get taken to Paisley Royal Infirmary. I think there was a dentist came in, but I don't remember it very clearly.

114. I didn't have any concerns surrounding the boys' mental health to the extent that I felt they may commit suicide. You could tell, from a layperson's perspective, observing their general demeanour, that there were some boys who were disturbed. I can remember one boy who used to hear voices and see things. It was quite unusual for boys to present with those sorts of things. There was very little evidence of self-harming amongst the boys. The boys didn't tend to cut themselves. They would more express frustrations outwardly verbally or they would run away. The absence of self-harming does surprise me a bit. I just don't think that it was taking place rather than us not being aware of it.

115. John Jamieson was the psychologist attached to the school. He was an ex-professional footballer who had played for Motherwell FC. He was part of the West of Scotland Training Group. He acted as an adviser to the headmaster and his deputies. He would give advice about the boys from a psychological point of view. I think he was involved quite a bit with the transition of boys from the old school block to the new units.

116. Another key psychiatrist who was attached to the Kibble was a guy called Fergus Stallard. He was a famous old Irish psychiatrist who was very well thought of. I don't remember ever seeing him coming into the Kibble. He worked out of the Douglas Inch Clinic in Glasgow. He had dealings with some of the boys who had mental health problems. There were a small number of boys who would go to the Douglas Inch Clinic to attend appointments with him. I never took any boys to see Fergus Stallard, but I heard his name mentioned and was aware of other staff members taking boys to go and see him at his clinic.

Deaths

117. There weren't any boys who died during my time at the Kibble. However, I remember receiving alarming phone calls from the outside concerning terrible things that had happened to family and friends of some of the boys. There would be messages received about deaths of siblings, close relatives or accidents that had happened. That gave me an insight into the sorts of lives the boys were living on the outside. Those sorts of messages would come to a member of staff in the first instance then, in turn, be passed on to a member of staff who had a decent relationship with the boy concerned. It would be that staff member's role to pass that information on. Care was taken not to worry or alarm the boy. There would be a worry that, if that wasn't handled correctly, then there would be a risk of that boy absconding.

Religious instruction

118. The Kibble was a non-denominational establishment. Rather surprisingly, I can't remember anything at all surrounding religion. I don't remember it even being considered or thought about. I don't, for example, ever remember seeing a bible in the school or ever seeing a religious person on the premises. Most boys would be going home for weekends so there would have been standard arrangements when it came to religion in their family when they went home. Looking back, there wasn't the slightest hint of any consideration being paid to anything other than Christianity.

Work / chores

119. I was at the Kibble around about the time of the Youth Opportunities Programme and Youth Training Schemes were beginning to be established. I think that some of the more able boys would have been involved with that. I have seen a comment online from Boyd McNicol, who taught Art at the school in the early eighties, saying there was a clear emphasis at an earlier time placed on working, building and fixing things. You could broadly describe that education as vocational.

120. By the time I arrived there was a shift towards a broader curriculum based professional education being provided. They were in the process of moving away from 'building things' towards helping young people learn how to get into a trade. Those trades were taught in the workshops rather than ad hoc and 'on site'. The trades taught were bricklaying, electrical work, painting and decorating and joinery. I don't know how educational those classes were or what qualifications they would have been getting.

121. Looking back, in comparison to what the boys would have received at a secondary school, I think practically that the boys would have been given a good start further to the education they received at the Kibble. Most of the boys at the Kibble would have given up attending secondary school in their first or second year so they wouldn't have been getting anything by way of education had they not been at a List D school. I think what they were getting at the Kibble was quite intensive. It was regular, every day and most of the boys seemed to engage with it. I think that, in terms of what their needs were, what they were getting was quite good.

122. It was the matron and the domestics' role to oversee laundry. I don't remember exactly what the laundry arrangements were, but the boys would have been taken care of. It was all batch living so everything would have been done 'en masse'. There weren't any chores when it came to looking after their clothing or doing things like polishing shoes. I know that was a thing in other List D establishments in Scotland like Geilsland in Beith, Ayrshire. The boys at the Kibble weren't inspected or anything like that. All that sort of thing was a thing of the past. Looking back, the boys weren't really helped with taking responsibility for looking after themselves at the Kibble. It was very institutionalised in that respect.

Christmas and birthdays

123. Most boys went home at Christmas time. I don't remember anything notable being done in the lead up to boys going home for Christmas to mark it in any way. There was usually a small number of boys still at the Kibble over the festive period itself. I recall that because I was on duty during that time. There was kind of a depressed gloomy atmosphere over the school. What was done was all low key because the

staffing level was low. The boys went into the healthcare pod. There were maybe only two or three boys. The boys were in their pyjamas for three or four days. They were given lots of chocolate and allowed to watch lots of television. I can remember thinking that it wasn't a great way for those boys to be spending their time.

124. Birthdays were marked if the residential childcare officer was aware and tuned into that. I can remember Bill Armstrong buying quite a disturbed lad a massive cigar for his birthday. That was quite against all the rules. The boy was absolutely delighted with himself. It was just such a nice thing for Bill Armstrong to do for the boy. If the matron had discovered that she probably would have been very disapproving.

Personal possessions / pocket money

125. The boys didn't have much by way of their own personal possessions. They might put up a few posters around about their bed space. I don't remember them having access to lockable cabinets or anything like that. I can't remember anything specifically, but I would be surprised if they were allowed to have anything like an expensive watch, a ring or something like that. There were no radios and it was the days before mobile phones. The boys were all mixed in together and it would have been difficult to keep personal things safely. Looking back, the Kibble wasn't very good with personalising things for the boys. There wasn't an individualised approach and there wasn't always a sense of the importance of privacy.

126. The boys received a small amount of pocket money each week. When I was responsible for the day boys, they were issued a small amount of pocket money alongside any bus and travel fares we provided. I can't remember exactly how pocket money was managed but it may have been contingent on the boy's attendance at the school. I remember that it was always difficult to reconcile the figures because boys would come to you claiming reimbursement and give you bus tickets that were two weeks old.

Visitors

127. Family members were certainly welcomed at the Kibble. There was a visiting session put aside on Sunday afternoons for family members for those boys who didn't go home for the weekends. Those sessions were held in the hall. The boys would make cups of tea and bring through cakes for their visitors. It was quite old fashioned and a bit formal, but I think the boys liked being involved in that way. If parents or family members wanted to visit outwith Sunday afternoons, they could. I can remember in the new units, family members would come and visit during the evenings. That wasn't that common but that did happen.

128. When I think about visitors visiting boys in the new units, it would have been fine for boys to speak alone. It was a lot lower key in the new units. There was an office that was glass fronted so privacy could be provided whilst supervision was in place at the same time. There were limited opportunities for boys to have private conversations in the old block school building when they had visitors. It was more difficult to manage because there weren't the facilities. There weren't any windowed rooms, and it would have been difficult to supervise boys being alone with their visitors.

129. I can remember social workers more frequently visiting boys in the new units. I don't think it was made too difficult for professional visitors to get access. I think they could visit at any time. That would have been something that was encouraged. Professional visitors were allowed to speak with the boys on their own, but they would also speak with me as well. Those conversations were generally focussed on behaviour. You would be in touch with social workers if a boy had run away, the boy's behaviour was poor or if there was anything else significant that had happened. There would be lots of conversations going on.

Family

130. I can't remember there being any siblings who were at the Kibble at the same time. I have been told that the Kibble did group work with families in the sixties. I was really impressed when I heard that. When I was at the Kibble, there was still in place a van

that would go around the outlying areas where the boys were living to undertake welfare visits on family homes. Those would be undertaken on school holidays when the boy would be at home. They were just quick welfare visits to make sure that everything was going ok at the young person's home. We would sometimes give money to the boy's family to help them care for him. I remember going out in the van a couple of times. Looking back, I don't think that we were always great at maintaining contact with families. Our contact was often quite limited. There would be contact made in the holidays or if there was a crisis and something bad had happened. However, there wasn't much routine contact made.

131. In my role as a keyworker, I was the first named person that boys would go to. I remember that there was a new boy who came in who had been living in Quarriers Village near Kilmacolm. He had no current contact with his family. When I started talking to him, he told me that some family members stayed in Castlemilk in Glasgow, and he gave me an address. Without saying anything to anybody, the subsequent weekend after the boy told me about his family, I went up to Castlemilk. I knocked on the door of the address the boy had given me and got hold of someone in his family. I then put the boy in contact with that family member. The boy was delighted. Looking back, that could have easily turned out to be a well-intentioned disaster and could have worked out badly. There was no checking done and there was no forethought gone into things like what the family's reaction would be. You would never do something like that now. Fortuitously, it worked out well.

Inspections

132. I don't remember seeing anyone coming in as far as inspections were concerned. Inspections were never mentioned and there were never any concerns expressed about their absence. There was no sense that there might be someone independent and outside of the organisation that might exercise some scrutiny on the establishment. At my level that was something that wasn't apparent. Inspections weren't something I was either conscious of at the time or something that I thought about. Looking back now, I do have concerns about the absence of inspections.

133. I remember there was a visit made by a person called Harry Richmond who was a senior person from the Social Work Services Group (SWSG). You could tell that Harry Richmond and GHK [redacted] had a good relationship. I think Harry Richmond came down to speak to us as part of one of the West of Scotland List D group training sessions. There was a big group of care workers from the Kibble and other List D establishments in the audience. He talked about his role and what the SWSG did.

Review of care / placement

134. As part of my role as a residential care worker, I had responsibilities as a key worker. The key worker role was just a way of organising the work. It gave staff members and boys more time to develop working relationships. A key worker would be given responsibility for about half a dozen boys. You would be those boys' first point of contact if they needed help with anything. If you weren't around, someone else would pick that up. I don't think that was formally designated. Key workers were responsible for making sure that the young person's physical, social and emotional needs were met within the establishment as far as possible. If there were any reports that needed to be completed it was the key worker's role to conduct those. If there was a social worker trying to get to know something about a particular young person, they would try and get hold of the key worker and speak to them in the first instance. If a boy had a conflict, or falling out, with a particular member of staff then changing key workers wouldn't be a problem. That would be only done if it wasn't seen to be colluding or causing other problems,

135. The key worker model worked okay at the Kibble. We all knew the young people we were working with and, sometimes, it might not be the key worker who had the best relationship with a particular young person. I can't remember boys changing their keyworkers during their time at the Kibble, but I don't think that would have been a problem. You would want to play to people's strengths and be as helpful as you could.

136. There was something that was called a section 20(a) review which, I think, was provided for under the Social Work (Scotland) Act 1968. I could be wrong about the specific clause and legislation. I think that under that section, reviews concerning each

individual boy's care should be undertaken at least every six months. Those reviews were the formal reviews undertaken and were chaired by a social work manager. There were also annual children's hearing reviews and internal reviews which would be chaired by the deputy headmaster. I can't remember how often the internal reviews were held. I was involved in all those reviews for young people.

137. I had quite a lot of involvement with children's hearings. The boy concerned would always be there. Their views would be sought, and they would be given an opportunity to speak. Whether they would speak or not varied. They were encouraged to put their views across by myself and the social worker present. We were all keen for young people to speak up because it could only help their cause. I'm pretty sure that residential care workers were expected to draft reports as part of their involvement in those hearings. The boys didn't have an independent advocate at the hearings and, looking back, that was a clear absence. There was no sense of that at all and that was a gap.

138. I can remember going to a children's hearing on my own in relation to a boy who was a day pupil and a school refuser. I remember the panel discussing what the boy's needs were and about him not attending school. For whatever reason, the panel decided that the best way to deal with the issue was to stick the boy into the Kibble as a residential boy. I remember that the panel asked me to phone the Kibble to see whether there was a place. I didn't have the confidence, knowledge or professional experience to feel I was in a place where I could challenge the panel members during the hearing. I was new to the job, and it was a formal setting. I can remember getting a row from John Turner, who was the head of education, the following day for allowing that decision to be made by the panel. Looking back, I was quite out my depth at the children's hearing. The outcome for that boy should never have happened. I wouldn't like to estimate how common those sorts of situations were, but my experience reflected the general lack of professionalism that was present at that time.

139. The relationships between the Kibble and outside professionals varied quite a bit. I wasn't a senior member of staff so I wasn't involved in any management meetings or anything like that. However, the impression I had was that the relationships that the

Kibble had with outside agencies pretty much depended heavily on the individual social worker. Those were relatively junior officers from the local authority. Some of those individuals were engaged and were positive but some of them were not. My impression was that the link between the school and the outside agencies was heavily dependent on what the social worker was like rather than there being a strategic plan, policy or practice.

Discharge / life after leaving the Kibble

140. There didn't seem to be lots of boys leaving during my time at the Kibble. Whether or not a high or low turnover is a good or bad thing very much depends on what the function of the unit is. I'm not sure the function of the Kibble was ever that clear so I can't comment on whether the low turnover of boys was a bad thing. There was a bit of a thing in the culture that the Kibble wanted to hang on to its boys for fear of being viewed as not being able to cope with difficult boys. There would have been politics involved in that because there were competitions between the heads of the various establishments.

141. I can't clearly remember the process and procedure for boys leaving. I don't know whether SNR [redacted] had the boy due to be discharged in his office before he left. It wouldn't surprise me if he did that sort of thing. GHK [redacted] knew all the boys and would have known a lot about them. It would have been a respectful thing to provide. I can imagine him providing boys with a bit of a pep talk on the way out. I'd expect GHK [redacted] to be respectful were he to have done all those things. I don't remember there being any rituals amongst the boys the night before young people left or there being any notable send-offs. It was probably more of a process thing than anything else. They would go away on the Friday and just not come back on the Monday rather than it being treated as some sort of remarkable event.

142. If a boy was under a panel order, there would be a review then an agreement as to how long the boy would be staying at the Kibble. There would be a natural completion time. The boys under Sheriff Court orders worked in a slightly different way. The boys were quite often from poor circumstances on the outside. They were underfed, weren't

sleeping properly, had bad hygiene and were sniffing glue. They were generally exposed to quite a lot of risks. I think because of that, to get any benefit, they would need to be with us for a while. It would have been counterproductive to take boys in and out of the Kibble for short periods of time. That would have been far more trouble than it was worth. A family placement for short periods of time would be perhaps more appropriate in those circumstances.

143. In terms of aftercare at that time, it would be very much over to the local authority social worker to manage that and maintain that sort of support. There wasn't capacity within the school to do very much of that at all. I do remember conversations that there was, before my time, a provision of aftercare officers. I believe that was part of the List D service. I don't think that was operating during the time I was at the Kibble. That may well have only existed been before local authority social workers were introduced. That could well have been before the Social Work (Scotland) Act 1968 came into force. Boys mostly tended to return to their family home after leaving the Kibble.

144. I remember that there were former residents that used to visit the Kibble. It was unusual but was something that happened. There was one man called [redacted] who was in his fifties and had stayed at the Kibble decades before. He wasn't involved with the boys and would mix with the staff. He worked on the farm that the establishment used to have at that time. I think [redacted] had been an orphan and had formed a strong relationship with the headmaster. I think he felt that the Kibble was part of his family and he had maintained contact because of that. He was just part of the furniture and, looking back, it was a nice, old-fashioned thing.

Boys running away or absconding

145. It would have been very difficult for a young person to opt out of something in terms of routines and practices. Boys were expected to get up in the mornings, go to classes and so on. The only way in which a boy could defy what was going on was through absconding. There was quite a lot of absconding going on. Boys could abscond and did run away quite a bit. Absconding acted a bit like a safety valve. There would be

elaborate rouses by the boys to stash clothing for when they wanted to abscond. I remember one time when half a dozen of them ran away from me when they were all wearing a football kit. I remember chasing boys down Paisley High Street who had absconded. I don't remember catching anybody I was pursuing.

146. There would be a standard sheet for describing events and noting down all the boy's known associates following boys running away. That information would be provided over the phone to the police. Boys who ran away tended to be boys that the police were familiar with. All that would be done immediately. Later, during office hours, you would let the boy's relevant local authority social worker know. Boys usually got picked up quickly. They were generally returned later that night by the police. Sometimes boys would just hand themselves back in.

147. You would let the social worker know when a boy who had absconded returned. I can't remember exactly what else would happen. The boy inevitably would be met with a sense of disapproval. They might be punished through not getting out for their next home leave. I can remember times when boys who had absconded would have their shoes taken off them. I remember going up to Oakbank in Aberdeen to collect a boy and that was done with him. Sometimes they would be put in their pyjamas in the sickbay. I don't know whether they were locked up in there or not. I can remember another occasion going out in a minibus to Saltcoats in Ayrshire to collect a boy who was in police custody. The boy was asked to take his shoes off when he got into the minibus and, when he was back at the school, he was put into pyjamas to limit his prospects of running away again. That sort of practice wasn't unusual. There was no use of handcuffs or any mechanical constraints.

148. You could get into a cycle of boys absconding, having their weekend leave taken away then running away again. That was difficult to resolve. The behaviour would either continue or just end up fading away. There would be some attempt to understand what was triggering that. We would try and have a conversation with the young person who was running away to discover why they were running away. You would be unlikely to get anything back. It was unlikely that a boy would say if there was something going on with other boys that made him want to abscond. The culture of not wanting to

appear to be 'grassing' people up was predominant amongst the boys. There were elements of that amongst the staff too. Culturally, it just wasn't acceptable to blow the whistle.

149. It did concern me that so many boys were absconding from the perspective that it was a stressor for the staff. Staff would be ridiculed and made to feel embarrassed if a boy under their care ran away. If a boy, as we called it, 'shot' on your shift and you were responsible, your colleagues would give you a hard time.

150. I didn't really worry about the boys' welfare and vulnerabilities when they ran away. That was probably because I didn't really understand it and viewed boys absconding as being an act of defiance or taking off out of a sense of adventure. When I look back it now and think about the consequences of what could have happened when a young person ran away, it makes me a lot more anxious thinking about what could have happened to them.

Discipline and punishment

151. I personally didn't have to discipline any boys myself. I don't remember seeing a code of conduct written down. It would have been clear and unambiguous to new members of staff what the rules were through observing and talking to the more experienced staff. There must have been disciplinary consequences for fights and assaults amongst the boys, but I don't remember a lot of that going on.

152. At some List D schools, they had a practice of invoking discipline through group punishments. They didn't do that at the Kibble. The Kibble was one of the first List D schools to do away with corporal punishment in the sixties. That was something that just wouldn't have been acceptable to [GHK redacted] under [SNR redacted]. There might have been some, what is called, 'token economy behaviour modification' approaches. That was an academic term that was used and popular in psychiatric hospitals in America in the 1950s. The overall principle of that approach underlined quite a lot of the work at the Kibble. I think if a boy attended school, and behaved well, they might receive more credits or get more pocket money. I think that system was

perhaps a bit more developed on the teaching side of the school and perhaps more amongst the staff who had come from social work backgrounds. I don't remember there being informal or formal use of segregation. The healthcare pod was used as a place to make sure boys who ran away took their socks and shoes off, or put on their pyjamas, but it wasn't lockable.

153. The most significant, and probably only, disciplinary measure that the Kibble used was stopping boys getting out for home leave at weekends. That was the leverage, deterrent and warning that was used by the staff. On a Friday afternoon the boys would be held in each one of the four dorms in the old block school. GHK [redacted] who SNR [redacted], was a key figure in all of that. He would sit down with [redacted] and look at all the reports of how the boys had behaved that week. He'd then decide whether each boy would get home leave or not. They deliberately extended their discussions so that the boys wouldn't get the position revealed to them until about 2:00 pm or 3:00 pm on the Friday afternoon. I remember the boys would be high as kites waiting to be told whether they would be getting home.

154. If a boy became so out of control that we couldn't look after them an unruly certificate could be sought. They were generally referred to as 'unruly orders' . In my experience unruly orders were rarely used. There were maybe only two or three occasions when I remember them being used. They were used when a boy was completely out of control and was taken away. Usually, the police would be involved. I think the police were really at the heart of it.

155. I'm not sure exactly what the process would have been that needed to be followed. It would have been dealt with by people at a much more senior level than me. It would have been down to the headmaster and deputy headmaster talking with those in the community who decided how to affect them. I do remember that there was a bit of a myth surrounding unruly orders and they were almost talked about in hushed terms. It was seen as a last resort in extreme situations.

156. Discipline was generally kept inside the establishment. Social workers didn't have a role in discipline and punishment. I can remember one occasion where a social worker

complained about the way we were disciplining a young person he was overseeing. I was only on the margins of that. I remember the boy's unit leader was flustered about the social worker coming in to speak to him. When the social worker arrived, GHK GHK came through, enthusiastically rubbing his hands saying "Yes, you're the social worker, I'm really looking forward to this." He completely put his unit manager at ease through doing that. I am quite sure GHK would have gone on to give the social worker a fair hearing. He wouldn't have wanted anything wrong or embarrassing happening in the units. If he didn't think staff were doing the right thing, he would be pulling them up. He would be right onto them, and he would do that in front of the boys.

157. The police generally didn't get involved with the behaviour of the boys within the Kibble. However, there was one occasion where that did occur. That incident was very much an exception. There was one weekend where one of the 'soft' team leaders was on duty. He was the more senior member of staff, and I was the more junior. The boys were in the main hall and were going round and round the senior staff member on their roller skates. There was a fear amongst the staff that if you reported something like that quickly it would be an admission of losing control and you would be regarded as weak. What should have been done was to quickly contact a senior manager. However, we waited and left it too long. I don't think I was confident enough, as a more junior member of staff, to make that decision but that is what I should have done. Ultimately, there was almost, what could loosely be described as, a riot and we ended up having to call the police. By the time the police came, the only way they could resolve things was to lift some of the boys for breach of the peace. We hadn't been able to deal with it quickly, promptly and effectively because of the culture within the establishment. As a result of that some of the boys were potentially disadvantaged.

158. It was embarrassing for the headmaster to have the police entering his school and exercising control over what he was supposed to be responsible for. It wasn't something he ever wanted to happen again. I remember that all the staff on shift were given a hard time by senior staff for not being able to handle the boys. The head of

education spoke to me personally about how disappointed he was, even though I felt I hadn't done anything wrong. It was a learning moment because he was right.

159. I didn't particularly have any concerns surrounding discipline and punishment at the Kibble. It didn't seem very unfair. It was a bit rough and ready, and we were all in it together, but I felt that everyone was treated fairly. I have no anxieties surrounding what was going on in that area at the Kibble.

Restraint

160. There was no training surrounding methods of restraint or advice for how you should act in those circumstances. I don't remember having any physical contact with anybody during the time I was at the Kibble. I don't even remember being pushed or pushing. I don't remember seeing that either. Looking back, that is surprising given we were working with volatile boys. They were quite big lads. We were working with quite well-developed teenage boys and some of them would have been strong.

161. The only thing that I can think of that might have come close to physical contact would be intervening in fights between the boys. However, that would have been done more in a common-sense way that you might take were you to see a couple of people fighting in the street. You would maybe shout at them or maybe separate them a bit.

Bullying

162. Undoubtedly, there would have been bullying going on amongst the boys. That wasn't something that was obviously apparent though. I didn't see that occurring directly. I think it was very much unrecognised. There was very little discussion about bullying at the Kibble. I don't think staff were particularly, unless it was obvious, alert to it. It wasn't something that was on the radar. I can't remember it being talked about at all. I suspect that the first route open to a young person who was being bullied, or having trouble at home, was to abscond rather than talking to somebody in the school.

163. Bullying wasn't spoken about and wasn't on the table. The boys themselves wouldn't have thought that they would have been listened to. There was such a power in-balance between the staff and the boys that they would inevitably not feel confident about raising anything. Boys speaking up about bullying just didn't arise so I don't know how staff would have dealt with that were that to have happened. It was hidden and under the radar.

164. Looking back, had I been a vulnerable young person at the Kibble at that time it would have been difficult to show any sign of not being in control. I think that would have been seen as a weakness by both residents and some of the staff. I'm confident that that wouldn't have been picked up by a member of staff. I don't think that bullying was something the staff were particularly tuned into. You would be more well prepared now to recognise and look out for signs like boys having more money than others and so on. I didn't have that awareness back then and, from speaking to colleagues, am aware that they weren't tuned in in that way as well.

Records

165. There were two offices for the care officers where the records were held. I can remember there being big dusty files which contained some good old-fashioned reports about each of the boys. They would contain up to date handwritten notes about what happened each day. There would also maybe be weekly summaries drafted as well. Those files were all held behind lock and key. I'm not exactly sure what records were kept surrounding discipline and punishment. I know that when the headmaster came along during his rounds, he would come along carrying some sort of log. I assume there would have been some record of that sort of thing there, but I don't know what happened with those logs or where they were kept.

166. In the front office there was a centralised daily log which recorded everything significant that had occurred on a shift. It was a place where all the 'need to know' information was placed. I remember one morning where there had been a lot of trouble the night before. GHK [redacted] had been called through to calm things down throughout the night. There were various incidents described in the note in the daily

log surrounding the night before made by GHK [redacted] At the end of his note, he added "note the phases of the moon." It had been a full moon the night before and I remember some of the staff laughing at the comment.

167. I'm not sure whether there was a visitors book but there would have been some sort of record made of visitors. I don't recall where, or whether, medical records were kept. There may well have been further confidential records held in the headmaster's office. I don't know what happened to the records at the Kibble. The management of the records would have ultimately fallen under Strathclyde Regional Council. They would have been the organisation who had oversight of the Kibble. Whatever they are now would be the organisation to approach to discover where the records are located now.

Awareness of abuse

168. On reflection, none of us were sufficiently informed about the abuse and trauma that some of the young people we worked with would have likely experienced. There was no training provided surrounding childhood trauma. I think childhood trauma was really underestimated at that time and people didn't have a clear understanding of the topic. The staff, generally, behaved in a polite, respectful way towards the boys on an individual basis, however, I'm not sure there would have been a sufficient understanding of what would be considered a 'trauma informed approach'. I certainly wouldn't have known anything about the topic at that time.

169. There was generally a lack of attention paid to previous abuse. It just wasn't a dominant factor in the minds of workers. I don't even recall more experienced colleagues discussing it. What would feature were instances where there were obvious signs, amongst the boys who came in, of physical neglect. If a boy had come from a poor background, and it was obvious that he was dirty, wasn't well clothed, underdeveloped physically or even potentially having physical bruises, that would have been noticed by the staff and addressed in some way.

170. In terms of socio, emotional and psychological adversity that the children may have faced at home or elsewhere, which we would now refer to as adverse childhood

experiences, we weren't specifically tuned into that at all. That set of circumstances could be linked to the fact that it was a very macho culture at the Kibble both amongst some of the staff and the boys. It was quite a traditional male dominated environment. Looking back, it would have been very difficult for any boys to actively reveal anything themselves for fear of being bullied, ridiculed or stigmatised by their peers. It wasn't the sort of place where it would have been easy for young people to reveal something like that. I think that would have meant it would have been difficult for staff to pick up on those sorts of things.

171. I don't have a strong anxiety about the Kibble. I'm certainly not as anxious as I am with some of the other establishments I encountered later in my career. It was a rough and tumble environment and some of the working practices were quite crude and basic. However, if something bad was happening the boys could run away. That, I think, is what happened. Quite possibly, if we had explored the circumstances behind boys running away more closely, we might have found what was really happening.

172. I didn't witness any abuse at the Kibble. Considering everything I have read about various other institutions, and the work the Inquiry is doing, it does surprise me that I am not aware of anything. It could just be that I wasn't tuned in or sensitive to things. It could be that staff members just didn't want to do things in front of me that might be considered abusive. Some of the staff were quite strict with the boys but the boys respected that. I don't regard the way those staff members behaved as abusive. I can't remember the concept of sexual abuse even being discussed. That was just something that people never thought about. Looking back now, I question whether anything bad happened that I could have prevented at the Kibble. I'm not sure there were things that happened but that isn't something I can rule out.

Reporting of abuse

173. The boys would complain about lots of different things. Those complaints would be more about being treated unfairly when not being given something. Their complaining wasn't ever in relation to their own welfare, neglect or abuse. There was never any

abuse reported or disclosed to me during my time at the Kibble. I would like to think that I would have done something were that to have occurred.

174. There was no formal structure like a protocol or a procedure concerning reporting processes. There was no clearly identifiable person for the boys to go and report things to. There was no independent advocacy, children's rights or independent external presence. It was a very closed institution in that respect. I suspect that the key worker would have been the person young people could report things to. Thinking about the concept generally, it was designed as a construct to organise work and build relationships with specific young people, rather than anything else. It was hoped that through those relationships a stronger bond may be formed that might create more trust between the young person and the staff member concerned. This worked reasonably well for practical purposes.

175. It was a male dominated environment at the Kibble. There were a small number of female staff who were more maternal in their approach. There was a matron, a nurse, a seamstress, a female teacher and a female residential childcare officer. From memory those female staff members would mop up more of the stuff surrounding concerns or worries that the boys may have had. There was a female worker who was a residential childcare officer in Mossedge. Mossedge was a unit that was designed for the younger age group. She represented quite a maternal figure for a lot of the younger boys. She paid more attention to things like whether they were eating properly and looking after their clothes. Those were things, perhaps in those days, that male members of staff wouldn't pay as close attention to with a teenage boy. She perhaps would notice things like boys being quiet, a bit tearful or maybe being withdrawn. I remember that she was good at picking up on those things amongst the boys she had in her care.

176. The impression I had was that the female staff members may be more the route that boys might go down if they wanted to discuss anything. It wasn't structured or organised. I don't think that was the intention when those female staff members were appointed, however, that was the role that they played. It was almost an instinctive approach that was created through traditional gender stereotypes. I don't think that

approach was solely restricted to the female staff though. There were staff, both male and female, who took on roles out of pragmatism rather than design. Jim Louden being the staff member welcoming boys to the establishment would be an example of that.

177. Looking back, I think it would have been difficult for a young person at the Kibble to have spoken either to me or any other member of staff about something really sensitive. They would inevitably be worried about what would happen with the information and that disclosing something might backfire on them. I'm sure that the boys would have absorbed a sense that 'grassing up' wasn't something that should be done. That culture was stronger than I experienced in some of the establishments I later worked. I would extend the culture of not being seen to 'grass up' to the staff as well. It would have been very difficult for a staff member to have spoken up against a colleague.

178. There was maybe the odd complaint that came in from social workers on the outside. However, I can't remember the precise nature of those complaints and my impression was that it wasn't a huge issue. I never had cause to make any complaints or report anything myself. I would have spoken to Jim Clark if I had any concerns because he was my mentor. I had a good relationship with Jim Clark. I think he would have been fair if I had reported anything. I'm quite sure that, if there had been anything dangerous or wrong, I could have spoken to him about it. He would have given me a fair response. Looking back, I was very much in learning mode, my confidence wasn't high, and my judgement wasn't developed. I was very much following the lead of my more experienced colleagues when it came to my practices.

Leaving the Kibble

179. My intention was always to leave the Kibble so that I could start my professional training. For someone of my age at that time, there was no future for an unqualified person remaining in residential childcare. I'd have just ended up continuing to bang away at the coalface under stressful circumstances. There was a danger that I would burn out were I to have carried on in that role for too long. Clive McKnight, who was

the deputy headmaster, encouraged me to go for professional training and that was what I applied to do. I was given references by the Kibble when I left by Bill Armstrong, who was a senior care officer, for the purposes of applying for my university course.

Geilsland Residential School, Beith, Ayrshire

180. Geilsland was a Church of Scotland establishment. I visited Geilsland during the time that I was at the Kibble on one occasion. That means I would have visited there some juncture between 1981 and 1982. Geilsland was viewed as perhaps one of the stricter List D establishments in Scotland. There was quite a lot of talk about other establishments whilst I was working at the Kibble. That talk could sometimes get quite competitive. Geilsland was regarded as a tough, strict, no-nonsense school. That was the word amongst the staff at the Kibble at the time. I think the staff at Geilsland put more emphasis on things like chores and polishing shoes than places like the Kibble. You would call it in today's terms a 'physical care model'.

181. SNR [redacted] EZD [redacted], was mentioned in relation to that culture. He was described as a powerful, strong, forceful character who was quite clear in his decision making and thinking. He was regarded as a strong [redacted]. I know that there was another guy [redacted] EZD [redacted] KMJ [redacted] He later became quite a prominent person in [redacted] I remember him as having quite a good reputation.

182. On one occasion I went, alongside another member of staff, to Geilsland to collect a boy who was being transferred back to the Kibble. I was the escort, or junior person, on the trip. We drove there in a jeep that the Kibble had use of. I can remember arriving and seeing quite an imposing building. It was very clean and everything was spic and span. It was a lot cleaner than the Kibble. I went to see the boy on my own. I might have been the person sent up to the collect the boy because I was younger and might appear less threatening. When I found the boy, he was upstairs in in one of the toilet areas cleaning. When I went through, I could see that he had his head down a toilet pan. He was sniffing a toilet block to get the effect off the solvent in it. I could see the boy was quite embarrassed about that when I found him.

183. I moved the boy into an open area in the adjacent dorm and had a bit of a chat. The boy had already been told that he was going to be moved. I believe his move was in relation to his glue sniffing. I can't remember exactly the nature of the conversation but it would have been along the lines of me trying to assure him that he was going to be ok, safe and that we would look after him. I would have assured him that it was a fresh start. With my knowledge of what I had of what Geilsland was like in mind, I think I was able to give him a message that he might find things easier at the new place he was coming to.

184. We then went downstairs and my colleague, a staff member from Geilsland and myself had some sort of brief conversation. I can't remember what that was about. We then left Geilsland with the boy. I can't remember anything further about the trip without speculating. Looking back, what I saw at Geilsland fitted with what I heard. To me it was unusually clean and spic and span. The only way that could have been achieved was through people putting in quite a lot of effort.

Larchgrove Remand Home, Glasgow / Longriggend Detention Centre, Airdrie

185. I regarded myself as a residential social worker up until the time I started working as a generic social worker with Central Regional Council. Those were really my formative years. I think it was because of that that I was always interested in hearing comments about other establishments that other people were working in. Anecdotally, there were two establishments that frequently came up. Unfortunately, I don't really remember the specifics of what was said, however, the accounts I heard all sounded plausible, persuasive and, I thought, probably accurate. They were all quite consistent and volunteered. Sometimes the things I heard were through overhearing boys talking about what they had experienced amongst themselves. Those boys wouldn't necessarily have noticed that I was there.

186. The first establishment I heard discussed was Larchgrove. I remember there were quite a few boys at the Kibble who came via Larchgrove. The anecdotal information I heard was all negative. I never remember one youngster talking positively about

Larchgrove. The boys would tell stories about the conditions at Larchgrove and the staff being abusive. They didn't go into any specifics. The boys would just say that the place was cruel and degrading. They referred to the establishment as 'The Grove' and it was almost spoken about as if it was a rite of passage that had to be endured. It really sounded like an awful place to be. I know that latterly there was an Inquiry undertaken into Larchgrove by Glasgow City Council and the report was viewed as being controversial.

187. The second place that frequently came up was Longriggend. I was aware from colleagues and from professional visits during my time as a social worker, that it was viewed as a cruel and unusual place. Any young person who spent any time there would talk about it as being militaristic, severe and austere. I would hear that the staff were punitive. By any objective, from what was described there was a very harsh regime there. I understand that the prison inspectorate themselves identified that in the late eighties.

188. I wasn't told the things I heard in confidence, however, I didn't take them any further. I was in a very junior position and wasn't confident enough to do anything. If the boys had been asked whether they wanted to make a formal complaint, they probably would have declined the offer. At that time, the concepts of children's rights and fairness were absent. There was no advocacy and there was no independent person the boys could speak to. Added into that, the culture of not 'grassing people up' was very strong amongst the boys. There was nothing at that time to counter that.

Period spent in England at Lingfield Hospital School, Lingfield, Surrey

189. I'm conscious that Lingfield Hospital School is an establishment that does not fall within the Inquiry's terms of reference. However, I did have some formative experiences there that impacted how I worked in Scottish establishments and the Scottish residential care sector later in my career.

190. After leaving the Kibble I decided to delay the start of my professional training for a year. I opted to take a job as a deputy house parent in a place called Lingfield Hospital

School. I worked in Lingfield Hospital School between 1982 and 1984. Lingfield Hospital School was a children's home located near to the villages of Lingfield and Felcourt in Surrey, England. It was a big Quarriers type village home surrounded by beautiful countryside. It was for youngsters who had epilepsy and neurological impairments. It was a very expansive campus consisting of twelve large houses. Each house catered for between twenty and twenty-five young people. It was an old-fashioned houseparent model. The model was intended to replicate a family environment. Looking back, it was rather an old-fashioned set up.

191. I remember that they couldn't get local people to work at Lingfield Hospital school because the wages were so low. It was set in a wealthy area of England. The man who oversaw Lingfield was a man called Gerald Loney. His brother worked at one of the List D schools in Scotland. Every year Gerald Loney would go to all the unemployment hotspots in the UK and recruit staff. He would go to Belfast, Glasgow and Cardiff. He would interview young folk who wanted to get experience under their belt so that they could go on to do social work courses. He was quite happy for recruits to come down for a year or eighteen months before moving on.

192. I heard about Lingfield through word of mouth and got tipped off an advert was due in the press and I advertised my availability. Gerald Loney then saw my profile and offered me an interview and following my interview, I was made an offer. I ended up being offered a slightly promoted post at Lingfield because of my experience working in a List D school. I don't know how far Lingfield went when it came to vetting and checking credentials back then. I would be surprised if they didn't make some contact with the Kibble. I don't know what my references, if they were sought, contained. I know that earlier on, Bill Armstrong, who was a senior residential care officer at the Kibble, gave me a reference to enable me to get me onto the social work course I deferred. That reference was positive and helped me get onto the course. I can only think, because of that, that there was positive stuff coming from the Kibble regarding me if those views were sought.

193. Gerald Loney told me that he thought, because of my experience, that I would be able to handle myself. He ended up putting me in a unit with a man called [redacted]

[redacted] oversaw the unit. Nothing explicit was ever said to me about the arrangement or [redacted]. However, my impression was that there were questions surrounding [redacted] practices and Gerald Loney wanted me to flush out what was going on. I appreciate that is speculation, however, I think that Gerald Loney may have had an instinct about [redacted] in some sort of way.

194. [redacted] would have probably been in his late twenties at the time. He lived in a flat attached to the unit. He was regarded as someone who could do the job, fix things and was an outgoing, confident character and someone who the children liked. I was the number two under [redacted]. We didn't get on because we were very different people. I thought he was a bit controlling and liked everything to be very clean. I remember that he would have me and all the other staff down on our knees cleaning radiators with toothbrushes and things like that.

195. The youngsters in the unit were between eight and twelve years old. During my time in the unit, I noticed that there was an attractive, articulate and charming little boy. That boy would quite often be taken by [redacted] into his flat on his own. [redacted] said that he would buy him sweets and watch television together with him. That boy was favoured and spoilt over all the other kids. I remember the boy's parents would come in regularly. They got on well with [redacted]. [redacted] was quite charming, the parents appeared to be very happy with what was going, and the boy appeared to be happy.

196. At the time I felt uneasy about what was going on. On reflection, I think about things more negatively. I sometimes think that there may have been something questionable going on when [redacted] took that boy up to his flat. I never reported what I saw because, at the time, I didn't feel there was anything sufficient to report. I didn't have any hard evidence to take things further. That's something that I regret. Were I to see those things now, I would be questioning them and challenging what was happening. From the perspective of where I am now, I think that this member of staff could have been grooming the boy. At the very least it was unprofessional conduct showing favouritism and spoiling a child within a group. There were no checks and balances or questions being asked about [redacted] behaviour.

197. I was ultimately moved off the unit where [redacted] worked following an incident. The children all wore these grey V-necked jumpers. One night, in haste, I chucked all the jumpers into the washing machine then walked away. When I later discovered the washing machine wasn't working, I turned the dial and thought nothing of it. When I came back about an hour later to pull out the jumpers, I discovered that they had been shrunk. [redacted] was furious with me, and he used that as the opportunity to have me moved on to another unit.

Period spent training to become a social worker at Glasgow University

198. I ultimately left Lingfield Hospital School to undertake my social work training at Glasgow University in 1984. It was a CQSW and a postgraduate diploma in social work. I graduated in 1986. Over the course of my degree, I had the opportunity to experience and observe residential care environments and spent time at an establishment called Southannan.

Southannan, Fairlie, Largs, Ayrshire

199. Southannan was a Quarriers establishment. In 1985 I undertook a two or three-month summer placement at Southannan as part of my course with Glasgow University. My title at Southannan was student social worker. From memory, I believe a fellow student and I spent about two or three weeks living at the establishment in one of the lodges.

200. I was interested in Southannan because I was aware of the things that the staff were doing there through my training. I really wanted their approach to work. I'd heard, through my course, that it was an interesting place, and it was a contrast to the places I had worked in the past. I was interested to see how it compared to other places I had worked in my career.

201. Southannan consisted of quite an imposing house stuck out in the countryside. There were between twelve and fourteen children staying there at any one time. They were

all younger children. It was boys and girls maybe between the ages of eight and ten years old. The establishment was for younger more 'disturbed' kids who hadn't been involved in offending. The word, which you wouldn't use today, used to describe the children was 'maladjusted.' They were children who had emotional difficulties who were more likely to hurt themselves and others. I remember that there were children there who would hurt animals and suffer from emotional outbursts.

202. I can't remember exactly what the geographical limit for children attending Southannan was. It might have been wider than the Kibble because it was more of a specialist establishment. I don't think any of the children there had been involved with the panel system or the criminal justice system. I don't think the children came from Quarriers because, by that time, it was either closed or in the process of being closed. I think the children were more likely to have come via referrals from educational psychologists.

203. There was a separate 'move on unit' that was used for older children in the local town. It only housed about two young people at a time and there was a small staff group. The staff supported the young people and taught them how to look after themselves. They taught things like shopping, cooking and so on. I visited there a couple of times, but I had no real involvement with that establishment.

204. Southannan was an interesting, progressive place because it was a 'Therapeutic Community'. It was at the opposite end of the scale to the Kibble when it came to permissive regime and having a progressive approach. There were pros and cons to that, but that was the structure that was in place.

205. The person in charge was a man called George Gill. I believe he was also in charge of the move on unit that was in the local town. He was well qualified and was a very strong paternal figure. He was very warm and nurturing. He would walk around, smoking his pipe, overseeing things and gently making sure everything was in order.

206. Joe Broussard was the deputy at Southannan. He was American and a wheelchair user. He had quite a lot of experience linking in with student teaching at Glasgow

University. He was well qualified and an interesting guy. I remember him being quite creative and imaginative. He very much took a 'whole child approach' to the children. He was very interested in everything about the child rather than being narrow and only looking at hard scientific statistics. He took a very broad approach to what he did. I think George Gill and Joe Broussard formed quite an impressive double act together.

207. There was a female staff member who supervised me called Janice, but I can't remember her second name. She was my practice teacher. She was a qualified social worker and worked alongside a few others. I remember that she had taken further training on training social workers herself.

208. All the staff were well qualified and, overall, it was a very nurturing environment. I remember that the decisions made at Southannan were made very much on a group basis. There would be a meeting every morning with all the staff and children present where everything would be thrashed out together. There was quite a lot of psychological input at those meetings. It was obvious that all the staff members were comfortable with challenging one another at meetings. They would challenge each other's practices and were encouraged to think about what they did and what the consequences were. The psychologist present would be the person facilitating all of that. It was all quite advanced in that respect.

209. The staff at Southannan didn't pay as much attention to boundaries and control as the other places I had previously worked. The culture was very permissive. If any children were distressed or upset, they would be allowed to 'act out'. I remember, because of that, there was a lot of damage to the property. Windows would get smashed a lot. It was considered, on balance, that the children who did those things weren't committing destructive acts. They were considered an opportunity to understand the child's behaviour in relation to their background. It seemed to me that it was a very civilised approach to residential childcare at that time.

210. Looking back, in terms of the way they treated the children, there was a lot of mutual respect. The child's dignity was respected. The staff paid attention to privacy and the individual needs of the child. In terms of effectiveness, I'm not sure whether ultimately

the approach taken in Southannan worked. I was a social work student at the time so I had done quite a lot of reading around what Southannan were trying to do. When I looked into it, through the reading that I was doing, I discovered that the research found that there wasn't much difference in terms of outcomes when comparing it to the outcomes at other types of establishment. There was discussion that the therapeutic community approach might not be the most effective way of doing things but it might be the right way to do things because it was a civilised and humane approach. The latter finding was kind of the conclusion that I preferred.

Time between completing CQSW and recruitment to Ballikinrain

211. The standard progression, career wise, after qualifying was to get a job in a fieldwork team. You would start as a generic worker with a local authority and build your career from there. Unfortunately, I couldn't get a job during the first round of applications. I had just qualified, was looking for a job and Ballikinrain came up as an opportunity. The role was probably advertised in The Glasgow Herald. I remember jobs were advertised on a Wednesday and a Friday and I probably picked it up from there. It was a type of work I was familiar with and it was geographically convenient for me at the time. I didn't know an awful lot about Ballikinrain before applied for the role there. I had a positive impression prior to going though. That impression perhaps became even more positive after being appointed.

212. I remember being interviewed by the headmaster, Douglas Davies, and the deputy headmaster, David Denholm. It was a formal process, and I was shown around part of the school. I'm pretty sure I had the opportunity to speak with some of the young people and they would have been asked for their views. I'm pretty sure they were asked comments about what they thought about me. Looking back on how I was recruited, it was a systematic and thorough interview process.

213. I'm pretty sure there would have been some sort of vetting undertaken prior to me starting at the school, however, I wouldn't be able to run through what that process would have been 'chapter and verse'. I'm certain that Ballikinrain wouldn't have appointed anybody without proper checks being undertaken. It was a Church of

Scotland school so they would have had their own processes and procedures. I would have provided a reference from someone at my university. They would have been my prime reference. I'm pretty sure that would have been Alan Barr, who was my tutor. My other referee might have been my practice teacher from Southannan. I can't remember whether any of my referees were spoken to.

Ballikinrain School, Balfron, Stirlingshire

214. I wasn't at Ballikinrain for a long time. It would have been about six months at some juncture over the course of 1986 or 1987. It was a Church of Scotland establishment.

Layout and structure of Ballikinrain

215. The building itself was really imposing but beautiful. It was a big castle in the middle of extensive grounds in the middle of the countryside. It was completely remote and was in the middle of a rural area. Although it was a large, quite imposing castle, they were able to create what felt like a warm and cosy atmosphere within the living areas. It was, as far as could be done, quite comfortable and met the needs of the children quite successfully. The establishment was very socially isolated and could be compared to an asylum in that way. There were huge positives to its location insomuch as the children were free, safe and able to run about safely. On the negative side there wasn't any integration with the local communities and the services there.

216. It wasn't a secure facility. If there was good weather the boys would be encouraged to go outside, and the doors would be open. They would just go out and play. There was discrete observation, but staff weren't generally slavishly standing next to youngsters. If you knew there was a problem, then there would be a presence but otherwise there wasn't. Getting outside was an outlet for the boys. They were safe and there wasn't anything dangerous lying about.

Funding

217. I'm not exactly sure where the funding came from. The Church of Scotland ran the establishment, but I think it was funded by local authorities. Most of the boys came

from Glasgow, and there were several beds that were funded and blocked out for use solely by them, so I imagine Glasgow City Council would have been one of the main funders.

General culture at Ballikinrain

218. It was old school residential childcare, but it was different to the places I had worked in the past. I remember that by the time I was at Ballikinrain there was a bit more emphasis on privacy and dignity and there was the emergence of things like children's rights. That was introduced through the influence of the more professional and qualified staff that worked in the units.

219. My first impressions were quite favourable. I'd always been interested in the line of work and wanted to continue supporting and defending it. I felt comfortable amongst my colleagues. I thought that the headmaster was a class act, and I liked the deputy as well. I remember that the boys were a lot of fun. They were a lot easier to manage than the older boys I had encountered at the Kibble.- I saw that it was quite different to the Kibble. It was a junior List D school. It didn't have the same macho approach. There wasn't the same stress around the place. I think that was because of the presence of younger children and the setting. The whole atmosphere and culture of the place was quite different to what I had been used to.

220. The good things that occurred at Ballikinrain were largely brought about through the work of the headmaster, Douglas Davies. The qualities that Douglas Davies possessed are important when trying to run these sorts of large, complicated places successfully. If you don't have people like Douglas Davies in charge it just starts going wrong underneath them. That can happen in any organisation.

221. Douglas Davies shared many of the positive characteristics that GHK [redacted] had. He was a very talented able man who was committed to the best interests of the children. He wanted children to be heard and treated like anyone else. He was open and happy to talk to anyone who might have a complaint or criticism. He set the right tone, tried to recruit the right people and fought to get as many resources as he could

into the school. In his own way, albeit you wouldn't have called it that at that time, he managed to create a therapeutic approach within the school. The way that he did that was through the way he conducted his business and communicated with the staff. The signals he provided to those around him set the scene.

Roles at Ballikinrain

222. I was hired as a qualified residential childcare officer. It was the same role I had at the Kibble except I was on a qualified grade. My responsibilities were much the same as they were at the Kibble. I was a key worker for between four and five children at any one time. I worked front and back shifts during the day. I didn't work nights. I didn't live at Ballikinrain, I lived in Stirling and travelled back and fore most days. If you were working late there was a staff bedroom where you could stay. That came into its own if there had been a lot of snow.

Staff structure and dynamics

223. It was a similar structure to the Kibble. There was a headmaster, head of care, head of education with team leaders below them. There were regular night staff who came in. There were more female staff members around when contrasted to places like the Kibble. I think the staffing levels were higher.

224. There was more of a professional approach amongst staff than the Kibble because of the number of qualified people that were there. I remember that the administrative staff, the cleaners and the helpers were all part of the group. I remember that some of those staff members had almost a maternal role around the children. They would put their arms around the boys or read them a story. That sort of thing was very much encouraged. It was used to normalise the care and to reduce the institutionalism that might occur amongst the boys. That was quite a strong feature at Ballikinrain and worked quite well, particularly considering the boys were younger.

225. Staff meetings were formal, structured and run professionally. Some of the staff would really engage with those meetings and it felt authentic. The recurring theme was to

discuss individual cases. The key worker would present the case and there would be input from education. Information would be shared in a constructive way with questions being asked followed by discussion.

226. At times I found the culture amongst the staff to be a little bit cliquey. That could be unhelpful at times. There were the same tensions between teachers and residential social workers present at Ballikinrain as I had experienced at the Kibble. It was perhaps more evident at Ballikinrain and could well have been a little bit worse. The collaboration between teams and staff wasn't as great as the Kibble. By way of example, I remember refereeing a football match one time. That's generally something you want to avoid in a List D school because everybody ends up arguing with the person in that role. Inevitably the boys would argue with you. On this occasion Greg Dougall, who was one of the teachers, argued with me. In some ways he was even worse than the boys. He was giving me a really hard time in front of the boys. I almost sent Greg Dougall off. I didn't do so because I didn't quite have the bottle to do that. Although it perhaps sounds a bit petty, the whole incident put me into a really difficult situation.

227. In general, I would say that the skills, qualifications and attitudes of the staff were sufficiently appropriate for the children we were working with. Most of the staff were well equipped, trained and had the aptitude. Some had a lot to offer, particularly those trained staff members who were involved with the outward-bound activities. They did a lot of good stuff with the children.

Staff

228. Douglas Davies was the headmaster. He was a big avuncular, warm, grandfather-type of figure. He came across as a 'wise old owl'. He was Welsh and had done a lot of work in England. He was an important figure. He was very experienced and out of the same stable as GHK [redacted] He had consummate skills in diplomacy. I remember Douglas Davies being politically astute and able to navigate the politics between himself, the Church of Scotland and what was going on within the school. He

was interested and good with the boys. He just exuded a calm reassurance and set a nice therapeutic tone. He came across as a positive charismatic leader.

229. David Denholm was head of care and deputy head. He was an interesting man who had a lot of interests. He was interested in sports and politics. He was a good deputy head who was very hands on and engaged. He had a lot of energy, enthusiasm and took a highly professional approach to his work. He put a lot of emphasis on a team approach and engaging with external social workers. You could tell that he was interested in the kids and enjoyed engaging with them. He had good attention to detail but understood the big picture as well. Looking back, he had a very clear idea about what his job was and took it seriously. He was encouraging and reassuring. I think that was what resulted in the staff having a lot of respect for him and approaching him for advice. I remember feeling comfortable with going to speak to him about anything that had gone wrong. You knew that you would receive useful advice rather than 'an unfair bollocking.' He was somebody who you could trust and was fair with both the colleagues and the children.

230. Neil McGuire was an experienced residential worker who I had a lot of respect for and acted as my mentor.

231. Alex McIvor was a residential care officer and one of my peers. He was from the north of Scotland and a really good guy.

232. Len Thompson was a unit leader. He generates a lot of positive comments from former residents on a Facebook page I am part of.

233. IGD [redacted] was a teacher and instructor. He was a member of the local mountain rescue team. He was a highly qualified outdoor educational specialist. He did a lot with the boys.

234. Greg Dougall was a teacher at Ballikinrain. He later rose to become the deputy headmaster at the school. He was a little bit older than me. He was a staff member who I found it difficult to relate to personally.

Recruitment

235. I don't think there was anyone recruited whilst I was at Ballikinrain so I wouldn't be able to comment on what the recruitment process for other staff would have been.

Qualifications and training of staff

236. There were many more qualified members of staff at Ballikinrain than the Kibble. I would say that the majority were qualified in something. Not all had gone through the CQSW and graduate diploma course. Ballikinrain already had quite a lot of qualified staff when I arrived. They were keen to attract people coming off courses. They were looking to professionalise the work that they were doing. The difficulty they had was that residential care was still regarded as a Cinderella service. It wasn't viewed, at that time, as something which constituted a career progression. That was true in my own personal case because the reason I applied was because I couldn't get a job in the local area team upon qualifying.

237. There was an induction process. The Church of Scotland had their own internal process for all new staff. I remember going to Glasgow and receiving some training very early on. I can't remember how long that process lasted. It would have been days here and there. There would have been an expectation that, having just come from a social work training course, you would have all the basic bits and pieces as far as child protection, legislation, linking with local authorities and all your general duties and responsibilities were concerned.

238. There was an expectation that staff would participate and continue with their training. That was more evident at Ballikinrain than it had been at the Kibble. I think the Church of Scotland did provide ongoing training. I remember that they had their own training department. I can remember one course where they trained us on how to write social histories of people. It was a report training type course.

Children

239. It was all boys. It was a junior List D as opposed to a senior one. The boys were younger than the Kibble and all between the ages of ten and fourteen years old. Ballikinrain was designed to be a place for more junior boys who had social, emotional and behavioural difficulties. Some of the boys would have been involved in offending but not all. They were quite often youngsters who would have lived in not very good conditions in schemes in Glasgow. I think all the children were there further to panel orders being made through the children's hearing system.

240. The turnover amongst the children was the same as the Kibble. It wasn't very high. I think there were between fifty and sixty boys at Ballikinrain in total. The numbers didn't peak much more than that. By that time List D schools were regarded as very expensive and perhaps not the best form of care. I remember that there was a push by Strathclyde Regional Council to find more foster care placements so that may have had an impact on the numbers of boys being allocated to Ballikinrain.

Relationship between the staff and boys

241. The quality of the relationships between the staff and the boys was different to the Kibble. I wouldn't say the relationships were any better than the Kibble because of the higher volume of qualified staff. I'm not sure whether there being more qualified staff had an impact on the quality of the relationships the staff had with the young people there. It was a different age group, but I would say there wasn't a lot in it. There were some strong nurturing positive role models at the Kibble who may not have been qualified but were still doing good stuff.

242. However, comparing the two, there was more nurturing going on at Ballikinrain. The children were younger and more of a therapeutic approach was taken towards them. The younger ones were helped to get to sleep at night. Looking back, both the Kibble and Ballikinrain were good with what they were doing when it came to staff and resident relationships, but in different ways.

243. There is a Facebook page for old boys of Ballikinrain which provides people, who were at Ballikinrain in the eighties and nineties, an opportunity to talk about their experiences. The comments on the page from former residents, who were there around about the time I was there, are all very positive. They say things like it was "the best years of my life" and so on. A lot of the positive comments surround the relationships between certain members of staff and the children. All of that is really encouraging. There are very few negative comments. Those comments that are negative are mostly about members of staff former residents think were not good.

Admission process for boys

244. I seem to remember that there was more attention given to due process when admitting boys. It was more formal than what I witnessed at the Kibble. The whole process seemed to be more professional. Referrals were considered at staff meetings in advance so that views could be sought on suitability. The head of care, David Denholm, was always keen whenever possible to involve and engage with social workers so I would think, if anything, he would have been chasing them for information when boys were being admitted. There would have been absolutely no block on that at all. I don't precisely remember what happened after new arrivals joined us at Ballikinrain.

Daily routine

245. The children would already be up by the time I started my shift at 8:00 am. After getting dressed and having their breakfast in a communal area, the boys had a bit of free time until 9:00 am. The children would then congregate in the hall. The headmaster or deputy headmaster would allocate where the boys would be going in terms of classes and workshops. The children then had classes or workshops until lunchtime. There was a break in the morning at 11:00 am. The boys would come back for lunch and would have about half an hour to play outside after eating. The children would then gather and once again be allocated their classes and workshops for the afternoon by the headmaster or deputy headmaster. There would then be classes or workshops up until teatime. The boys would come back to have their tea then go to their units

afterwards. Whoever oversaw that shift would organise and arrange what would be happening that evening. The evenings provided more variety for the boys than the Kibble. There was more planning and thought put into that by the staff. The activities were much better organised.

246. I worked weekends. There weren't as many children left at Ballikinrain over weekends as there were at the Kibble. It was quite relaxed and informal at the weekends. It wasn't particularly structured. I don't remember taking boys out in a vehicle, like we did at the Kibble, but there was more stuff to do on site. There were the grounds, tree houses, football pitches and so on. There was quite a lot that you could make something of. You could get involved with games or just go for a walk.

Mealtimes

247. The food was better than the Kibble. I don't remember there being any complaints. I remember mealtimes being quite institutional. The boys would sit four to a table with a staff member sitting at the top to supervise. A centralised trolley would be brought round, and the food would be served to the boys. Like the Kibble, the staff didn't generally eat with the boys and had their meals elsewhere.

Sleeping arrangements

248. The boys slept in bedrooms rather than dormitories. However, the rooms were still shared. They were big rooms with about two or three beds per room. The boys' sleeping spaces were a lot more personalised and they had a lot more of their own stuff than the Kibble. The bedrooms were comfortable and cosy. They were more suitable for children and had more of a family feel about them.

249. I think there were different times for bedtimes for the boys. The boys who were younger would go to bed earlier. The older kids would stay up a bit longer. It was the responsibility of the day shift staff to get the boys ready for bed before the night care staff came on. They would generally come on shift after the children were in their bedrooms.

250. I can't remember how bed-wetting was dealt with at Ballikinrain. Interestingly, it didn't seem to be as much of a feature amongst the boys as it had been at the Kibble. There wasn't the pervading smell of urine in the bedrooms that was a feature at the Kibble. Looking back, it could be that the boys at Ballikinrain felt safer. They were younger and weren't surrounded by older, physical, potentially dangerous boys, as was the case in the Kibble. The boys were sleeping in small bedrooms rather than dormitories. That environment might have meant that there was less anxiety amongst the boys in Ballikinrain when compared to the boys in the Kibble.

Washing and bathing

251. I think what was provided at Ballikinrain was better than at the Kibble. It was bathrooms rather than the 'all in one' arrangement that the Kibble had. There were showers with cubicles and there were baths. I can't remember exactly what happened, but bath and shower times would have been supervised. It wasn't a free for all and was organised and planned. There would have been discrete observation and supervision to make sure everything was going to plan, and children weren't getting into difficulties. That seemed to all work quite well.

Leisure time

252. Ballikinrain would have been quite a contrast to the environments that a lot of the children would have grown up in on the schemes in Glasgow. They were right out in the countryside, could run around and had access to things like tree huts. In the evenings the children might watch television, go out for a walk or play sports. There were quizzes, puzzles, games and craft activities organised by the staff.

253. Some of the outward-bound staff would teach their activities in the evenings. I remember those activities being popular. There was a big emphasis on outdoor education with things like canoeing, camping, mountaineering, archery and yachting all being done. Ballikinrain really had some very capable people who were organising and overseeing those activities. They were all well qualified instructors. I remember

that there was one member of staff who would get the boys up at 6:30 am for a run. The boys said they hated it, but you could tell that they loved it. I remember that member of staff being great with the boys.

254. It was heaven for the boys in a lot of ways because they were being given opportunities that they never had before. There was a lot organised but, at the same time, there was a recognition that the boys needed their own space for themselves rather than programming everything. There were televisions in each of the dorms, there were radios, books and puzzles. In that way, it was more homely and comfortable than the environment at the Kibble.

Trips and holidays

255. I can't remember going out in minibuses to places with the boys as much as we did at the Kibble. I don't recall going on any holidays, however, I know there were trips abroad to places like France. I was never involved with any of that.

Clothing / uniform

256. I don't remember the boys wearing a uniform. I can't remember exactly, but I think it was more personalised when it came to clothing than the Kibble. The boys were able to wear their own clothes. I don't know how clothing was funded.

Schooling

257. Teaching and education were delivered on-site in a similar way to the Kibble. There was a separate education unit where the teaching was delivered. I think all the children were educated in the classrooms and workshops at the school rather than going elsewhere. It was more classroom based than the Kibble but there were some workshop things for the boys to do. I would say there was probably a wider selection of things for boys to do than the Kibble given the country setup.

258. I think the quality of the education and teaching was pretty good. The impression I got was that the teachers were a committed bunch who showed an interest in the children.

I remember that the teachers had quite a lot to offer, and each had other things that they could bring in with them. I remember one guy being a member of the mountain rescue team. He was a highly qualified instructor, so he was able to take children out to do all sorts of outward-bound things. There was another guy who had his own farm. He was able to use that in a helpful way with some of the young people. I remember him taking some of the kids out on his tractor and they loved it.

259. There was a lot more education surrounding life skills for the boys at Ballikinrain than I saw at the Kibble. Within one of the units there was a small kitchen and bedsit area that allowed boys to perhaps stretch their wings a little bit more. Age and maturity would allow boys to be admitted to that unit. The unit allowed the boys to have a little bit more independence. I can remember doing cooking classes with some of the boys using the kitchen within the unit. That wouldn't have been something that I could have done at the Kibble.

Healthcare

260. I think there was a local GP. There's something makes me think that he was the headmaster's son. There was a health centre in Balfron, and I think that was the first port of call if children were ill. I can't remember there being regular health checks. My impression was that the quality of healthcare was better than what was provided at the Kibble. I don't remember taking children to the health centre, hospital or anything like that. I remember there being more cuts and bruises because the children were out and about a lot more than the Kibble. That was just through young people being boisterous and exercising. The staff were first aid trained so I never saw that as an issue.

261. The children who were at Ballikinrain more presented with behavioural difficulties rather than problems with mental health. I remember one boy who emptied his bowels in a tree hut and that was seen as a bit of a drama. However, that was seen as part of the difficulties he had. It wasn't regarded as naughty behaviour, and all received in context. I don't remember there being a lot of self-harm and I can't remember there

being any psychiatric input. There was educational psychology but nothing really beyond that.

262. It wasn't really a medical setup. I found that to be quite normal. It fitted in with the normal types of approaches taken in residential care at that time. I know that if there was anything serious, they wouldn't have taken any chances. Staff would have taken any boy to the senior residential officer were there anything to have happened. Everybody was cautious in that respect.

Deaths

263. There were no deaths during my time at Ballikinrain. I seem to recall that there had been some boys who went missing on a hill some years before I started at the establishment. I'm not certain about it but I believe a boy died. I don't know any detail beyond that. That incident was still spoken about amongst the staff when I was there. People were still traumatised by the incident. The discussion surrounding the incident left me with the impression that it had all been fed into people taking their responsibilities very seriously.

Religious instruction

264. Ballikinrain was run by the Church of Scotland. They did religious services in the school surrounding Christmas, festivals and so on. They were more formal and structured than the Kibble in that way. I can't remember whether children were expected to go to church over the weekends they stayed at the establishment.

Christmas and birthdays

265. I don't think I was there over a Christmas period. Birthdays were celebrated. People were more tuned into birthdays, and it was treated sensitively. That was especially so with the younger children. I think there were cards, presents and families were encouraged to be in touch. There was much more attention paid to that than there

was at the Kibble. I think that was partly down to the influence of there being more female staff.

Personal possessions / pocket money

266. The boys had more possessions than they had at the Kibble. I don't remember the boys having lockers or there being a problem with possessions going missing.

267. Pocket money was provided. I can't exactly remember the routine surrounding that. I think it was issued to them prior to them going home for weekends. I don't remember pocket money ever being withheld as a punishment.

Visitors

268. I don't remember any family members visiting boys at Ballikinrain. I think that was more because of the location of the school than anything else. It was a difficult place to get to. The school wouldn't have been against family members visiting. There was more use of the telephone at Ballikinrain than the Kibble. I can't remember boys phoning home directly but there was more family contact present.

269. There was an active involvement with external social workers. The deputy headmaster, David Denholm, was keen to involve social workers. That was particularly the case when things weren't working out with individual young people. I remember every Monday morning we would phone up the social work department to update them on how things had gone the previous week and what was going on the subsequent week. David Denholm was quite keen on that practice. He would ask us to alert social workers to any difficulties and get us to bring social workers in where possible. I can remember being encouraged to do that.

270. When social workers visited, they were able to speak with the boys on their own. They were also able to speak with me. That was all easier to do as a qualified worker. I was able to speak with more confidence and authority because I understood more

about what their role was. I think, because of that, it was easier to reach agreements about things.

Family

271. I don't remember there being any siblings there. Contact with family was encouraged though. The boys could go home at weekends so they would, more than often, have contact that way. It was a similar arrangement to the Kibble when it came to home leave. They used the school minibus to take boys back and forth to Glasgow. We were in quite an isolated location so that would have been the only way that could have been done. That all seemed to work quite well.

Inspections

272. I don't remember there being any inspections. I wasn't at Ballikinrain all that long and was a basic grade member of staff so I wouldn't have been involved if there were. I'm pretty sure that there would have been inspections undertaken. Ballikinrain was a Church of Scotland establishment with most of its children coming from Glasgow City Council but it was located within Central Region Council. If it was up and running them, I think it would have been the quality and assurance department of Central Region Council who would have been responsible for inspecting Ballikinrain. In my later experience at Dock Street, I found them pretty good.

Review of care / placement

273. I attended children's hearings alongside the children I was the key worker for. I also attended reviews. By that time I was more confident and a lot more assertive at hearings. I felt that I was able to represent young people in a much more professional way. I was clear about the purpose and function of the hearings, my own role and what should happen. Looking back, I think I was able to do my job at the hearings much more effectively.

Children running away / absconding

274. There was a problem with children running away. The frequency of that happening was maybe not quite as much as the Kibble. I think that was partly because the boys were younger at Ballikinrain. It was a different scenario to the Kibble because Ballikinrain wasn't close to motorways, train stations, bus stations and so on. It was in the middle of nowhere and there were no streetlights. Looking back, that could be potentially more dangerous, especially if the weather was bad and absconders went off the main roads.

275. I can remember one case where the staff were particularly worried. There were two or three boys who ran off and were found to have stolen a car from Killearn. It was embarrassing for the headmaster because that was the village where he lived, however, we were all more worried about the safety of the boys and the public. We went out in a school vehicle to find the boys, but we didn't get them. The boys ended up coming back in the early hours of the morning the following day. I think they were brought back by the police.

276. I don't remember shoes being taken off boys when they returned. They would have been spoken to by their key worker and given a row. Staff would have tried to find out what the reasons behind the absconding were. It would have probably been a wee bit easier to find out those reasons than the Kibble because the 'no grassing' culture was less well developed. You would act on that as well as you could if you were able to establish the reasons.

Discharge / Life after leaving Ballikinrain

277. It was more marked and celebrated when boys left Ballikinrain than the Kibble. The headmaster would issue everybody who was departing with a photograph of the school before they left. I believe he would have spoken to the child himself and there probably would have been an announcement made at the morning assembly in the hall. The provision of aftercare was much in the same manner as it had been at the

Kibble. The management of all of that was handed across to the young person's local authority social worker.

Discipline and punishment

278. The way discipline was managed at Ballikinrain would be the way that the Kibble would have liked to have operated back in 1982 after moving to the open units. I don't think we took away home leave by way of punishment. We didn't use corporal punishment. Discipline was exercised through the quality of the relationships. Those relationships were pretty good. We would speak to boys to understand why they weren't happy. Where there was misbehaviour, we would express disapproval but provide explanations for that disapproval. That was the method used rather than depriving the children of something.

279. I don't remember seeing anything written down when it came to discipline and rules. There would have been corporate stuff put out by the Church of Scotland but that all would have been generic. There must have been a general mission statement, or statement of purpose, about what the school was all about. That would have been used for referrals and things like that. I don't remember that being codified in any detail for new staff.

Restraint

280. Restraint took place at Ballikinrain. There was no training for staff around that. It wasn't regulated and there weren't any checks or balances. There wasn't any guidance or advice on how to approach situations. I can't remember seeing other staff restraining boys but that must have happened. I know that when I restrained boys it wasn't seen as an aberration or something that was unique. I wouldn't have done it if I hadn't seen other people doing it. Restraint would have been cursorily recorded. There would be a reference to it in the logbook. It wouldn't have been properly recorded like it would be now with reasons, duration, length of time, debrief and so on being entered.

281. I can remember an occasion when I had to sit on a boy for at least half an hour just to try and calm him down. He was little lad who, I think, had been fighting quite aggressively with somebody else. He was very agitated, angry, running about wild in a threatening way and it just blew up all of a sudden. I took a common-sense approach to react in a way that an adult would over a child when trying to contain them. It was in an evening so there wouldn't have been many other staff around. I was exhausted at the end of that experience, God knows how the boy felt. I remember that the boy kept bucking and struggling and thinking that it wasn't safe for him. I had no training and all I was trying to do was hold the boy to stop him from hurting himself and other people. Looking back, I wasn't using any approved techniques and wasn't paying attention to how long it went on for. There weren't any other staff involved with overseeing the incident. It wasn't checked or questioned and was just something that I did. On reflection, it could have gone terribly wrong but fortunately it didn't.

282. I don't think there was any training concerning restraint available surrounding the time I was at Ballikinrain. I'm not sure how I would have learned to use restraint at that time given I hadn't had any training. I hadn't been shown any techniques at all. I think the technique I used would have just been instinctive. I was doing what I felt was right under the circumstances. Looking back with the experience and training I have now, it was all quite poor practice really. I am quite embarrassed about the risks and the damage I could have caused to the boy.

Bullying

283. I can't remember witnessing any bullying directly, but it would have happened amongst the boys. I think there was a bit more awareness amongst staff that bullying would have taken place. I think the younger children were a little more willing to talk more openly. Because of that it was easier to gauge whether they were upset with the older lads. I can't remember anything more specific on that.

Records

284. There was generally a more professional approach towards records and recordkeeping than the Kibble. I felt that the quality of the documentation and records was better. Those impressions could have been formed more because I was noticing things, because I was trained and qualified, than there being a difference. You were expected to keep up to date notes and the verbal flow of information was good. Unlike the Kibble, there was a meeting every morning with the deputy headmaster where he was given feedback on what had been going on the night shift before. I think the standard of record keeping and communication was generally higher because the staff were better qualified.

285. The records were used as source material for the purposes of drafting reports for the panels at children's hearings. The purpose of the records I personally created were to keep an up-to-date log of all the events and changes in relation to the young people. It was also so I could build a developing picture and link that with whatever the goals in the care plans were.

286. Everybody could have access to the records that they needed. It was all on paper because there weren't any computers. I don't know what happened to all the records. I imagine they would have been archived by the Church of Scotland. Either that or they would be archived with Central Regional Council because that was where the school was located, or with Glasgow City Council, because that was where most of the children came to the school via.

Awareness of abuse

287. I never witnessed anything that I would regard as abusive behaviour. I think the higher levels of qualified staff helped to potentially prevent or detect abuse. However, I am not sure whether, ultimately, we were aware of all the things that were going on. I don't think it would be fair to compare Ballikinrain to what I experienced in that regard at the Kibble because there was a four-year gap between my time at both establishments.

Greg Dougall

288. Greg Dougall was a teacher at Ballikinrain. He later rose to become the deputy headmaster at the school. He was a little bit older than me. He was a staff member who I found difficult to relate to. I found him extremely difficult to engage with on a work basis. That is unusual for me because I don't usually have that sort of problem at work. It was the same sort of dynamic that I had experienced with [redacted] at Lingfield Hospital School. Apart from Greg Dougall's behaviour being extremely irritating towards me personally, and his sort of aloof slightly superior attitude, I never observed anything that I would consider as abuse directly.

289. I understand it from the press that Greg Dougall was suspended following allegations surfacing connected to a previous establishment he had worked at in Stirlingshire. The reports might have been published in about 1991, roughly four years after I left. I don't believe the allegations surrounded anything sexual, from recollection, the allegations surrounded physical mistreatment of children. I don't know whether there was a police investigation. I believe that Greg Dougall moved down to England following the allegations surfacing.

290. When I learnt what had happened with Greg Dougall, I wasn't actually completely surprised. It made some sense to me when I reflected on the way he was with me. If he was acting in the way he was towards me then he could well have been acting in the same manner towards young people.

Reporting of abuse

291. By the time I was at Ballikinrain there had been developments when it came to children's rights. Things like 'Who Cares' and more external scrutiny were starting to be considered and put in place. Things had moved on so the situation, when it came to opportunities and structures to report things, might have been better than what had been in place at the Kibble when I was there.

292. Where I think both establishments were weak was the absence of any independent advocacy, carers or organisations. Those sort of bodies and individuals weren't on the ground at either the Kibble or Ballikinrain. There wasn't a quick safe place for young people to go if they wanted to report something that was troubling them. They had to rely on a staff member who was 'in house.' I doubt whether there was always someone available for the boys to report things to.

293. Looking at Ballikinrain in particular, I think that some of the boys would have trusted me enough to say something if they felt they needed to. However, that maybe wouldn't have been the case with all the boys. I think it is more likely that some of the female staff would have been viewed as a safe easy place for discussing things. I remember those staff having a more maternal and nurturing role. That was particularly so with some of the female care workers and the younger children. That comes through from the posts I see on the former residents' Facebook page. Some of the female staff members were loved and seen as 'mothers in absentia.'

294. If there had been a concern or a complaint, I think the most likely avenue that boys would have used was through their local authority social worker. Social workers would have then raised concerns. Given the way David Denholm operated, he would have taken anything like that really seriously. I don't think that he would have dismissed it and would have been anxious to make sure that everything got sorted out properly.

Leaving Ballikinrain / time spent as a generic social worker

295. I was quite up front with David Denholm the Deputy Headmaster that I needed to leave to progress my career. We had a good relationship, so he was aware of what I wanted to do. I ultimately left Ballikinrain when I got a job working as a qualified generic social worker for Central Regional Council. That would have been in approximately 1987. David Denholm was disappointed that I had to go but he understood the reasons behind the move. He was provided as a referee, and I am quite sure that the HR department at Central Regional Council would have followed that reference up.

296. I worked as a generic social worker based in Stirling for a couple of years up until approximately 1989. At that time the natural progression, as far as social work careers went, was to spend a couple of years as a generic social worker identifying what your interests were then starting to apply for more specialist roles. For me that was a role as a prison social worker. I suppose working at HMP Glenochil was a natural progression from the work I had done previously. Quite a few of the prisoners there were people I had worked with at the Kibble when they were boys. They had graduated to being adult prisoners at HMP Glenochil. Eight or nine years on they were now inmates.

297. Because I was already working as a general worker for Central Region Council the role at HMP Glenochil was like an internal appointment. Central Region Council was one of the larger local authorities and they had a big professional centralised personnel department. I recall them being quite good and very thorough. I am quite sure that they would have gone through all of the correct procedures when it came to recruiting and vetting me for the role. Because it was a role within a prison, extra checks would have had to have been carried out. I think those comprised of additional police checks being undertaken. I don't specifically remember being asked for references, however I'm quite sure that would have been part of their systems and processes and they would have done everything correctly.

HMYOI Glenochil, Alloa, Clackmannanshire

298. I worked as a prison based social worker between approximately 1989 and 1991. At that time HMP Glenochil had a young offenders' element to it alongside a detention centre. The Home Secretary at the time, William Whitelaw, was encouraging a '*Short, sharp, shock*' approach to young offenders. The Scottish version of that was ran at HMP Glenochil. I can't say a lot about HMP Glenochil, but I do have some general thoughts and observations about my time there.

Layout and structure of HMP Glenochil

299. HMP Glenochil was both a HMP and HMYOI. There were four halls, named 'A', 'B', 'C' and 'D' Hall which housed the adult population. There was a separate, newer, part which was a detention centre which housed the young offenders. The detention centre was a small, self-contained unit.

Role at HMP and HMYOI Glenochil

300. Our team consisted of one senior social worker and four main-grade social workers. I was a main-grade prison-based social worker. It was my responsibility to provide a social work service to the prisoners in the establishment. Part of the role was providing a welfare service. There were several different tasks which we were involved in. They could consist of assisting with housing or helping where there were difficulties with the prisoner's family relationships. We might assist with issues surrounding contact with children. Sometimes it was simple things like liaising with the prisoner's family to look after the prisoner's dog at home if they had unexpectedly found themselves in the establishment.

301. We would get involved during a sentence where there where mental health problems and psychological support needed to be put in place. That might be where the individual prisoner was suicidal. That was more an example of the multi-disciplinary work that we did. Alongside the welfare service we provided, we also had a role in, what you would call now, public protection work. That was more of a professional role in trying to help the individual prisoner with opportunities. We would do that whilst liaising with people in the community to make sure that there was support outside when they were released. We drafted parole reports, risk assessment reports and would liaise with the police when people were getting released. We didn't have Multi Agency Public Protection (MAPP) in those days. I think that more formalised system across the various agencies wasn't introduced until the nineties.

302. In theory, we would have a rounded engagement with the prisoners. In practice, our work tended to be more focussed on the welfare aspects of the work. That was more

the area where the prison officers tended not to want to get involved. That caused a little bit of tension because, at that time, prison officers were trained to become involved in the welfare side of their work. The prison officers seemed to be solely focussed on dealing with security than anything else. They tended to view that their role being to maintain discipline and to make sure that the security of the estate was maintained. Ultimately, that meant we were limited in the amount of professional work that we could do. It meant that we didn't have the time to do as much as we would have wanted.

303. I was allocated to A Hall. At that time there had been a great deal of disruption to the prison service in Scotland following a riot at HMP Peterhead in 1989. The idea was that the problems present at HMP Peterhead would be diluted through dispersing the problem prisoners. The prisoners were dispersed across the estate and many of those prisoners ended up in HMP Glenochil. Some of the key ring leaders were allocated to A Hall. Unfortunately, those prisoners continued to cause massive disruption. There were dirty protests, fights and they set fires. The situation really did get out of control. It got that bad that staff would refuse to go into the galleries and put the prisoners' food through grilled gates. My role was to help prison officers speak to the prisoners because they refused to speak to the officers. Both sides had dug in, and they were suspicious of each other. I was seen as a neutral party. I would pass on things like messages about family members and that sort of thing. I know that the governor was grateful that I could help in that way because it was something his own staff found difficult to do.

304. I don't think there was anyone under the age of eighteen held in A Hall. I can't remember whether there were any young offenders moved across from the detention centre to the halls. I have a vague memory of discussions surrounding difficulties integrating young offenders into the adult population, but I can't say for certain whether that happened. In my experience, the young people were all held in the detention centre which was separate from the four halls.

305. We would go across to the detention centre on request. If one of the offenders wanted to see a social worker, they would apply to a prison officer. We would get that

information then go across. I'm not aware of any examples where requests were made by young offenders that were refused by prison officers. However, it is difficult to say whether that didn't happen. We wouldn't have become aware of things where requests were refused. Looking back, I would be surprised if requests were refused. In most cases, the level of our involvement would be quite light touch. It wouldn't really be in depth. We would see three or four different young offenders at a time on each visit. I can remember going across on a regular basis. It maybe, on average, took up about a day of my week in terms of workload.

Staff

306. I can't remember who the first governor was when I arrived. Jimmy Milne was the second governor during my time at HMP Glenochil. He was an old school gentleman. He was a former PE instructor who had risen through the ranks. I remember him being a compassionate and straight man. I viewed him at the time as someone who wouldn't tolerate any bad behaviour amongst the staff. I remember both the governors I encountered at HMP Glenochil being old fashioned gentleman governors. I think they were both quite liberal in their ideas. They would have been quite firm when it came to their discipline, but I got the sense that they were fair. I respected them and found both to have good values.

307. Latterly, there was one maverick governor. His name was Gordon Jackson. He took over just after I left. He was only there for a short time. I think the thought was that he would come in, be very strict and sort things out following the disorder.

308. He was quite a controversial character and was present for a period when HMP Glenochil lost control of its prisoners. The prisoners were on dirty protest, there was a lockdown in place and there were families at the gates protesting. They ultimately brought in the TV cameras to shine a light on what the conditions were like within the prison. I believe Scottish Television made a programme about it. Gordon Jackson ultimately got into some difficulties himself. According to press reports he was found to be in illegal possession of ammunition. I remember that receiving a fair amount of press coverage at the time.

Children

309. There was a detention centre on site, but I can't exactly remember how it was used in terms of the young offenders. It was all boys. I couldn't say how many were held in the detention centre, but it wasn't in the hundreds. I'm not certain what the age group was in the detention centre, I think it was between eighteen and twenty one. They were all serving short sentences. I think they were all three-month sentences.

310. When I was called across, I would try to get information regarding the young offender I was going across to see. The turnover was relatively high amongst the young offenders so we didn't have as much information as we would have had with the more longer-term adult prison population. In most cases we wouldn't have an awful lot of information. There might be a bit more information provided on the higher profile cases which might go further. Amongst the information we received, there might be information about schooling and family background.

311. There was one individual who I went to see fairly frequently by the name of [redacted] He would have been seventeen at the time. I am not sure whether he was on remand or had been convicted. He was more of an unusual example of the young people I would go and see in the detention centre. I think, at that time, he was in for a fraud type of offence. He subsequently went on to commit more serious offences including sexual offences. He had previously been a pupil at a List G school called Woodlands in Newton Stewart, Dumfries and Galloway.

312. [redacted] was a complex and difficult individual. I remember that he was in a suicide gown because there was a concern that he may pose a risk to himself. The gown was a smock made of heavy material that was stitched tightly so it couldn't unravel and be formed into a ligature. He was held in segregation and didn't mix with the rest of the population. My boss thought that it might be good for my professional development to build up a rapport with [redacted]. My role was to build up a relationship, get a sense about how he was managing things and to try and find out whether there was anything we could do to help him get through his sentence safely. I can remember getting in touch with family and trying to sort visits out for [redacted]. I remember that there

was a lot of tension between him and his parents. I believe his parents did ultimately come out and visit him. I remember getting in touch with his area social worker. It was a complicated and interesting case and [redacted] got through his sentence.

Deaths

313. I am not sure exactly whether it was in the detention centre or in the halls, but there was a cluster of suicides amongst young people at HMP Glenochil. I would estimate they occurred in the early to mid-eighties prior to my time at the establishment. The senior social worker I worked with was part of the committee who investigated that. The report was called The Chiswick Report and was published in 1985. It was named after the psychiatrist who worked on it, Derek Chiswick. He was attached to the Royal Edinburgh Hospital. Bob Stark, who was a senior social worker and my boss, was on the panel alongside the head nurse from HMP Glenochil, Alex Spencer, who was the deputy governor at HMP Glenochil, and a psychologist called Pamela Baldwin. I knew Pamela Baldwin from university days in Stirling. She was a couple of years ahead of me. It's a really well written report and a very interesting piece of work. The findings were that there was a bullying culture amongst the prisoners.

314. I remember it was reported that there was a group of prisoners called 'the wolves'. The wolves would shout out of windows and try to intimidate new people coming in. That was seen to be a factor in some of the deaths at the establishment. It was found that those youngsters hadn't wanted to follow through on their attempts but more it was instances where the act had gone wrong. The report seemed to suggest that their suicide attempts were a way of the young people dealing with stressful situations. I seem to remember that it was thought that the young people were attempting suicide so that they could be moved to different establishments.

315. There were lots of recommendations made about how things could be addressed. There was a strong minority view in the report expressed by someone who I think was Pamela Baldwin. It was suggested that HMP Glenochil should have been closed. In their view, suicide had become a way of coping. It was on the table, available and

was a possibility. The view was that the only way you could stop that culture was through closing the establishment for a period of time.

316. The suicides at HMP Glenochil ultimately just disappeared. Looking back it is not clear why this was the case. Ten years later there was a cluster of suicides at HMP Cornton Vale. That was only just up the road from HMP Glenochil.

Inspections

317. I have no recollection of inspections being undertaken. However, I was too junior to get involved in anything like that. I had no direct involvement with anything like that at all. There would have been Her Majesty's Inspectorate of Prisons for Scotland (HMIPS) inspections of the establishment. I read things in the press since where HMIPS have found the culture at HMP Glenochil as being too lax and that may have been a cause for riots that had happened since.

318. In terms of professional scrutiny of the social work being done in HMP Glenochil, the management was quite sound. There was a principal officer who had responsibility for criminal justice and the social work department. He was an ex-probation officer and he had quite good knowledge about the field. I remember him being quite pally with my senior and seeing him coming into the department once a week.

Review of care / placement

319. I had no direct exposure to reviews of the young offenders' ongoing care. Our involvement all came further to requests and was ad-hoc. I remember adults being subject to parole assessments and becoming involved with that. However, that didn't happen with the young people in the detention centre.

320. I remember being involved as the social worker with a convicted sex offender who was from Fraserburgh. He had been convicted of assaulting his daughter. I supervised a visit by that same daughter. My job was to make sure that the family had the right to meet each other in a safe situation. There was a recognition that there was a high risk

of repeat offending at that time for that group of prisoners. That level of involvement and ongoing assessment didn't extend to the youth offenders.

Discipline and punishment

321. The lads lived under a very strict harsh regime. Even I found it quite intimidating going across to the detention centre. The idea was that they would be given extreme discipline and exercise and that they would be exhausted. It was hoped that their punishment would help them clear their heads and make them think about where they were going in their lives. From the perspective of a junior social worker at that time, I felt that the whole structure seemed to be overly punitive. The prison staff didn't really talk with the young people. Staff referred to each other with the prefix "Mr". There was a lot of shouting, and the boys were only referred to by their second names. The atmosphere was quite different to the one that was in the halls.

322. There was nothing in terms of child protection or children's rights within the detention centre. The culture was so opposed to those sorts of things. It was all about control and discipline. That was the one thing that was seen to be important to enforce. The lads across there just seemed to accept the way they were treated. If anything, they viewed their experience at HMP Glenochil as a badge of honour when they got through it. It showed their peers that they were 'tough guys' and could handle anything that was thrown at them.

Restraint

323. I can't remember seeing staff put any hands on the young offenders. There must have been restraint used in the detention centre, however, I never witnessed any of that. In other prisons I remember hearing alarm bells going and seeing prison officers running all over the place. I don't remember that happening in the detention centre. It could well be that, because it was such a controlled environment, there was no need for that.

Records

324. We kept social work records and, from recollection, they were reasonably thorough. It was before the days of computer records being kept. Each prisoner would have a separate social work file. We would create a case note after visiting each young offender in their file. We would note any contact with the prison staff or family concerning the individual. We would have followed Central Regional Council's processes surrounding record keeping and retention practices. The files were securely held in the social work department and would have ultimately been archived with Central Regional Council.

325. The prison would have had separate criminal records held centrally. They'd contain information surrounding warrants and things like that. It would be more legal material. Those records might contain copies of any relevant social work material in amongst them. That would have been so the parole officer would have something from all the different departments to look at.

Awareness of abuse

326. It was difficult to see into the detention centre. It wasn't very transparent at all. Even as a professional in the prison, you didn't have full access. The young offender would be brought to you then taken away. I think, because of that, you didn't get a complete view of what was going on. You could hear things in the background, such as shouting, but you didn't have a full sense of what was going on.

327. The only thing that I can remember quite clearly, that may be considered as abuse, was the way that the staff would shout at the boys. There was 'no back chat' and no way for the lads to respond to that. To someone coming in, it looked like a military arrangement that was in place. It was all about strong discipline and compliance. I never saw what happened if the lads didn't comply or gave backchat. I've no doubt there would have been some disciplinary measure in response, but I can't remember what that would have been. I imagine that, because there was so much control, all of that would have been very tightly administered.

Reporting of abuse

328. Even though I felt I gained some sort of trust with the young offenders I was working with, I don't think that any of them would have had the confidence to report things that were happening in the detention centre to me. Looking back, I suppose it shows just how institutionalised I was. I just didn't think about questioning what was going on at the time.

Leaving HMP Glenochil for SACRO / time spent working with SACRO

329. I applied for the job with SACRO in 1991. The reason for me wanting to leave HMP Glenochil was that I had a young family. The role with SACRO offered a promotion and paid better than the role I had.

330. SACRO stood for the Scottish Association of Care and Rehabilitation of Offenders. Although that was the name, the organisation probably placed more of an emphasis on public protection than anything else. I worked for about six months with SACRO as a Senior Development Officer in central Edinburgh between approximately 1991 and 1992. I was responsible for a variety of offender related programmes. It was the first role where I had management responsibilities.

331. The only thing that might be of interest to the Inquiry was that I was responsible for a member of staff who ran the volunteer befriender scheme at HMP Saughton at that time. One of the volunteers had come back to the staff member and volunteered some information connected to the Orkney child abuse case. I'm not sure of the detail but it was about something that had happened in Orkney, and it had a bearing on the case. I think that one of the principal characters accused of abuse was being held at the prison on remand at the time and, whatever was disclosed, was related to him. The staff member came to me and asked what she should do with the information. We had a conversation, but I can't remember what we ultimately decided to do.

332. If we were a local authority organisation, it would have been clear what we should do, and it would have been reported immediately. If there was the slightest hint of anything we wouldn't have hesitated to report things to the police. There would be the

presumption that reporting to the police would be more important than confidentiality. In our situation, we were dealing with a voluntary organisation that didn't have many practices and procedures. There was a lot more emphasis placed on confidentiality in the setting we were within. It was a new organisation, and the procedures just weren't that clear. It became more of an ethical discussion rather than thinking practically what we should do.

333. If I were I in the same situation now, I absolutely know what I would have said and done. Although I can't remember exactly what I said or did, I think I may have vacillated a lot more. Looking back, it was a clear example of responses being problematic where there is a lack of clarity.

Brodie Youth Centre, Falkirk, Stirlingshire

334. Secondary Institutions - to be published later

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Leaving SACRO and recruitment process to Dock Street

338. When I saw the advert for the unit manager role at Dock Street it looked very attractive. I noticed that Central Regional Council had increased the salaries and conditions of service for all the staff working in the children's units. It was unusual to see managers of children's homes being renumerated the same as senior social workers. The rate of pay was really very good indeed. Indeed, the rates in Central Regional Council were higher than elsewhere for senior social workers. My interest was stimulated by the advert, and I made some enquiries. I knew some of the people who worked in the area and asked them their views. Ultimately, I decided that the role was an attractive one that would progress my career within residential childcare. That had previously not been a path that would have offered rewards for qualified persons such as me. I applied at some time in 1992 and was offered an interview.

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Secondary Institutions - to be published later

Secondary Institutions - to be published later In the end, I was offered the position and was delighted when I got it.

340. Secondary Institutions - to be published later

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Dock Street Children's Home, Dock Street, Carronshore, Falkirk

343. I was appointed as the unit manager of Dock Street Children's Home in either 1991 or 1992 and was there until 1995. Secondary Institutions - to be published later

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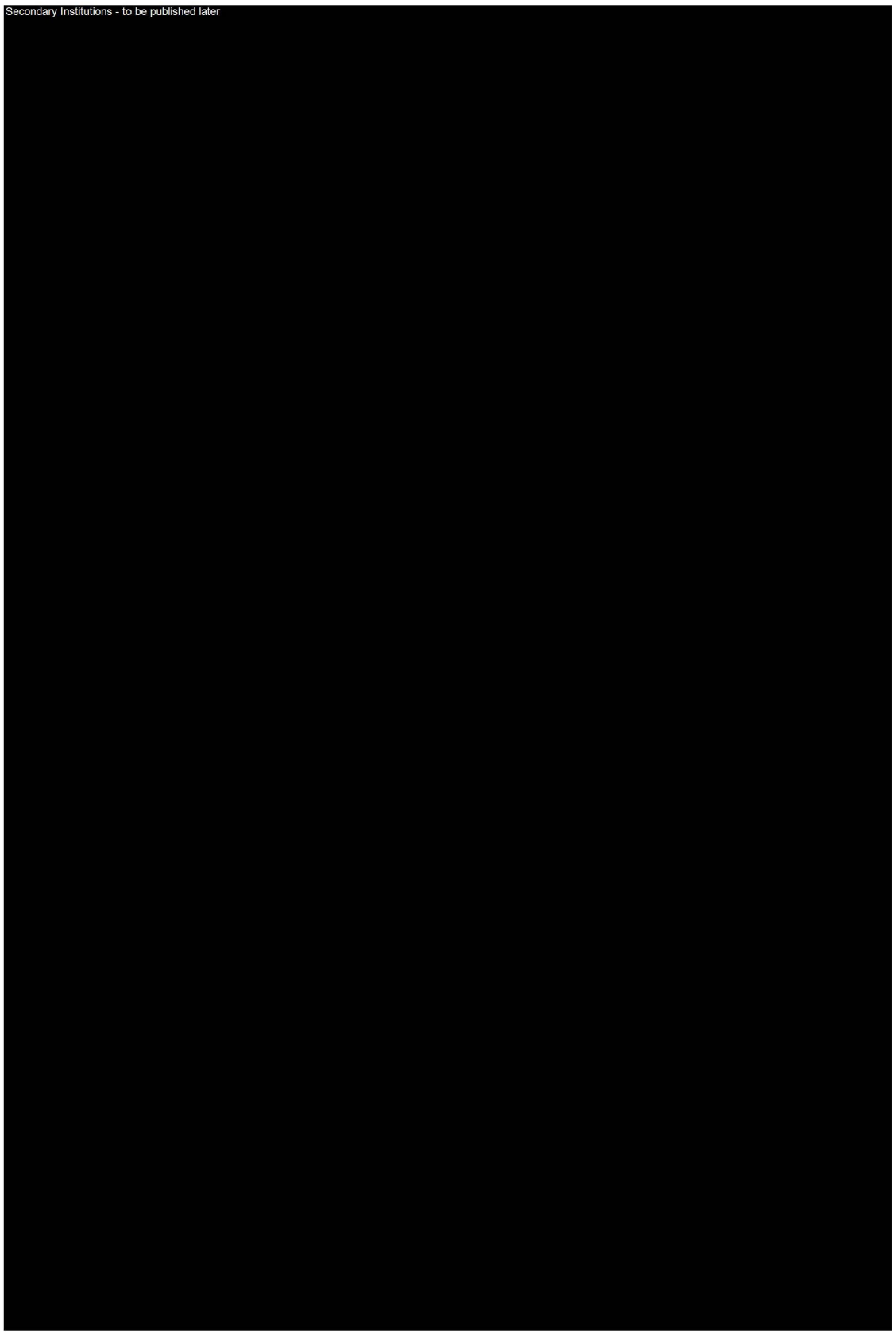

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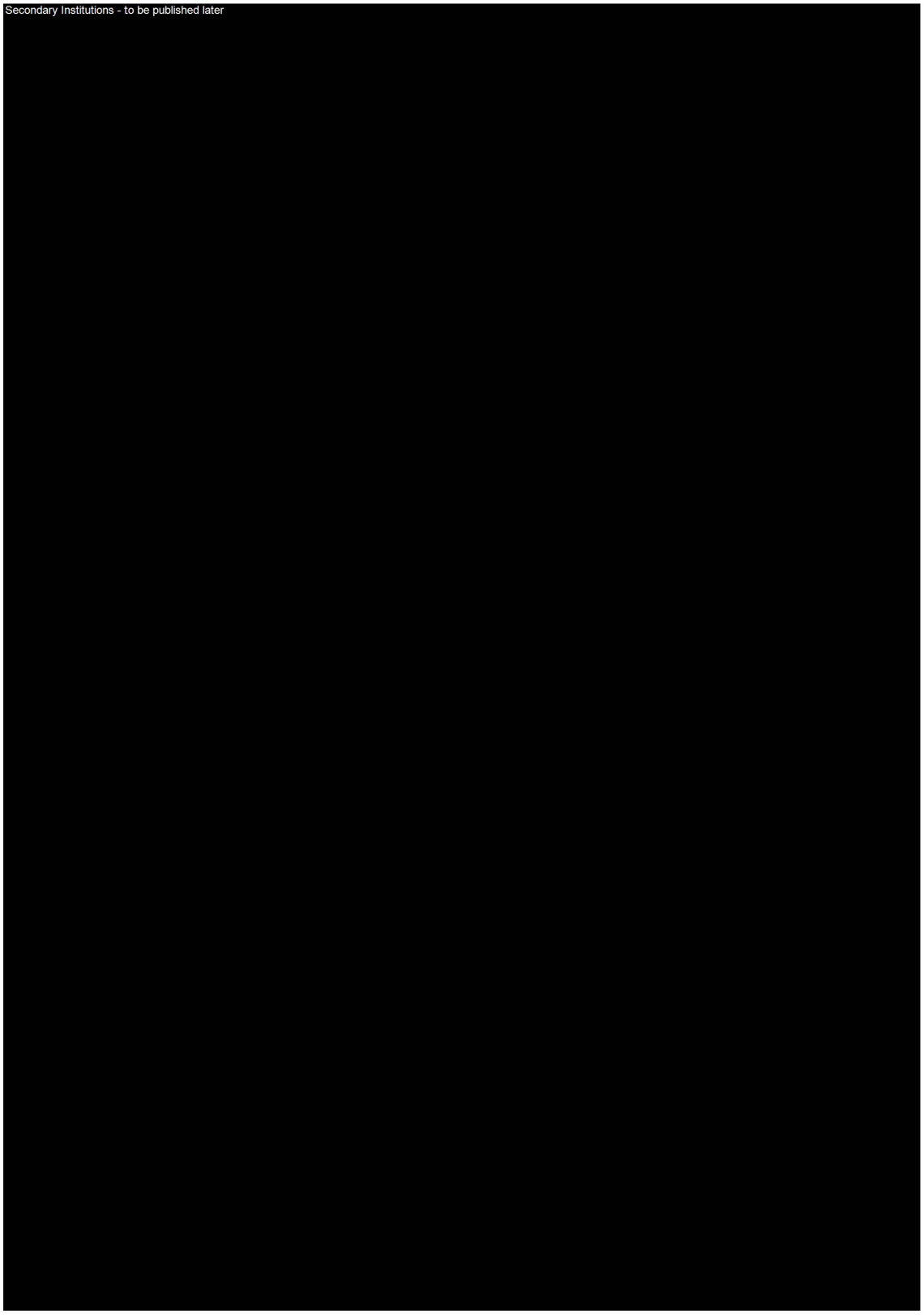

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461. As part of the commitments made by the council, Nick Pigeon, who was the training manager for Central Regional Council, and I attended a course in 1995 in Milwaukee in America. It could well have been much earlier than 1995 Secondary Institutions - to be published later

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462. Nick Pigeon was from Cumbria and, I think, he came from a social work background, working in fostering and adoption. He was quite an experienced person in that field already. Nick and I were some of the first people in Scotland to undertake that course and to go across to make links with the people who were developing the course at Cornell University. We were delighted that Central Regional Council were able and willing to provide us with that opportunity.

463. Nick Pigeon brought that training across to Scotland to introduce across Central Regional Council. Ultimately, all staff in Central Regional Council were given therapeutic crisis intervention training. Nick Pigeon provided most of that training, but I believe there were other staff involved. I believe some people from America came across and may well have also provided some of the training. It was a huge commitment by Central Regional Council and cost them a lot of money. However, it provided a strong signal that they were trying to professionalise the work that was going on at that time. It was a big undertaking, and it was taken seriously by the council. It really was quite impressive.

464. I think it took three days to receive the basic level of therapeutic crisis intervention training. It was carried out at meeting rooms in hotels with no distractions. Plenty of time was provided for staff members to do it. There was time to discuss and reflect on what was being provided. The staff liked the training because it was high quality and was delivered by experts. Those experts were good theoretically but were also good trainers at the same time. They understood what it was like to work in children's homes and the pressures and constraints staff were operating under.

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499. [redacted]

IQX [redacted]

500. I appointed IQX [redacted] as a part time social worker at HMP Cornton Vale, where I subsequently took a position as a senior social worker. That would have been at some juncture between 1995 and 2000. She had qualified, come into the service and applied for the role at HMP Cornton Vale. It's quite possible that she had applied for the role because she had known me. She had previously been a residential social worker at the Brodie Youth Centre. Secondary Institutions - to be published later [redacted]

Secondary Institutions - to be published later [redacted]

Secondary Institutions - to be published later [redacted] As far as I was concerned, she came with a good background and her reputation was positive. IQX [redacted] was interviewed in the normal way, performed well and was appointed

501. [redacted] came to us from HMYOI Polmont where she had been working as a full-time social worker. She went through all the standard procedures and checks when she joined us. She asked me whether she could get every Monday off as annual leave because there was something she needed to do to get time off for. I agreed to that. About three or four months into her appointment, I had a phone call from the governor at HMP Cornton Vale. She said that he didn't want [redacted] coming in the following day. I was told that [redacted] was under surveillance by the security department and they were trying to establish whether she was having a relationship with a young offender at HMYOI Polmont. It was alleged that she was using her Mondays to go and visit the young person concerned and was planning on setting up together with him when he left HMYOI Polmont. All of that came as a complete bolt out of the blue to me. After that information was disclosed to me, I phoned up the Chief Social Work Officer at Stirling Council and reported what I had been told. He wasn't interested at all in what I was saying, and I was left to deal with it on my own.

502. I phoned [redacted] up at home, described the situation and told her not to come into work the following day. She was in complete denial about being involved with the young person. She was suspended before having a disciplinary hearing. I believe she resigned before she was sacked. [redacted] was someone who I knew, trusted and thought was reliable. She had been through all the procedures, yet she was still found to be someone who had acted very inappropriately around young people.

503. Bizarrely, I was contacted by [redacted] sometime after she left HMP Cornton Vale for a reference. I received the letter of request from her at my desk. I think she was looking for a job in social care. I remember passing on her letter to the HR department at Central Regional Council's social work department with no comment. I wasn't sure how to treat her request and I don't know how it was ultimately dealt with, but I didn't personally provide her with a reference.

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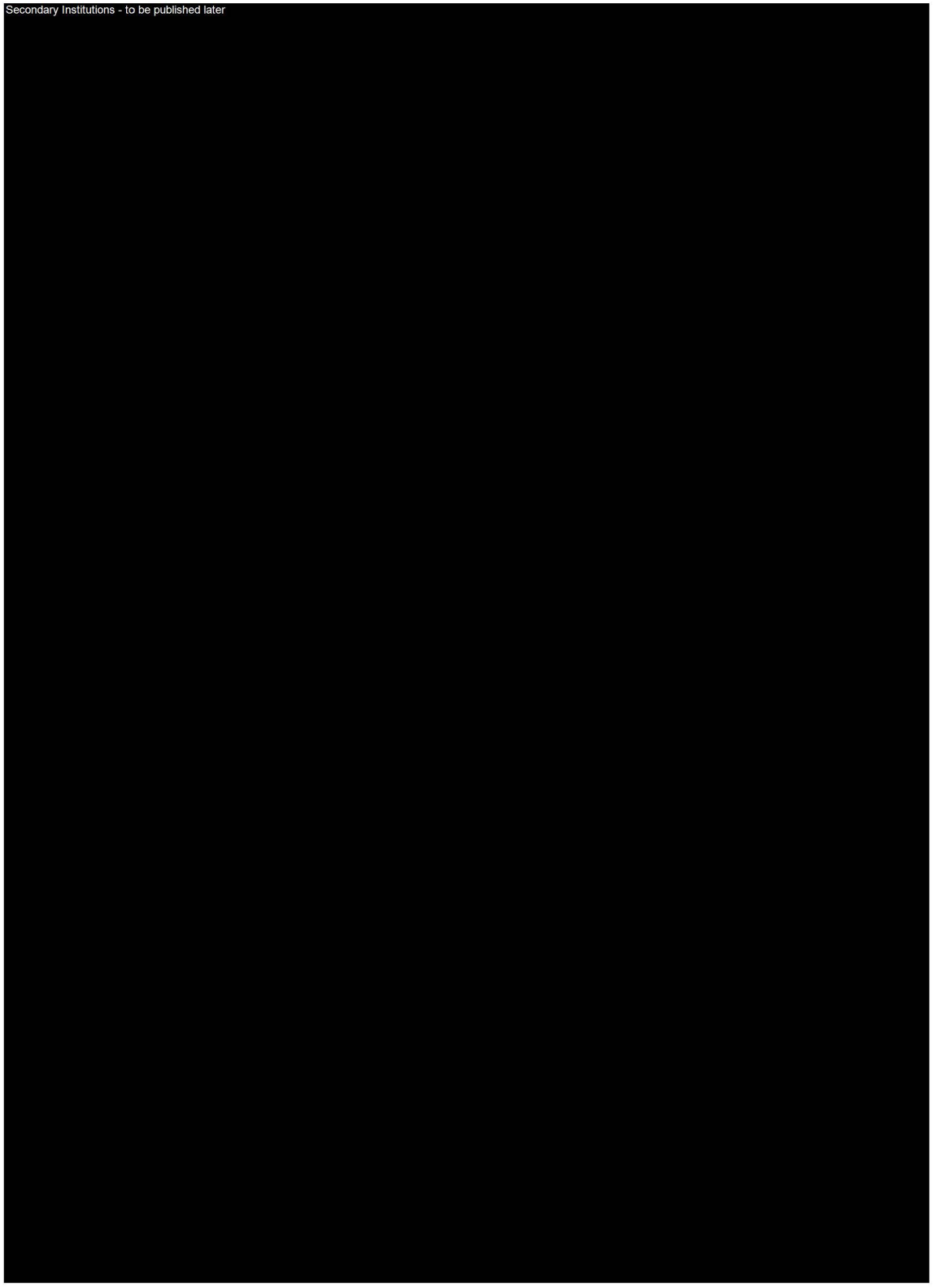

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508. [redacted]

Leaving Dock Street Children's Home and recruitment to HMP Cornton Vale

509. The senior job at HMP Cornton Vale was my dream job. I had felt for a long time that it was one of the best social work jobs in Scotland. I knew that it would be an interesting place to work. I realised that it wasn't a big management job as there were only three social workers there. I had previously applied for the role around about the time that I had applied for my role with SACRO. Unfortunately, at that time they decided that they needed to readvertise the role because they felt they didn't have a strong enough shortlist. Because of that, when I was offered my role with SACRO I

took that opportunity up. During my time at SACRO I was called by the head of criminal justice, asking me to reapply for the role. I'd only been in my role at SACRO for four weeks. I felt that I just wasn't in a position at that time to apply for it at that time.

510. Five years later the role came up again. It had always been on my radar, and I decided to apply again. I remember that when I applied for the job, I was shortlisted with three female candidates. When I was offered the job, they took up a grievance with the council and the equal opportunities commission. It was in the papers and everything.

HMP Cornton Vale, Stirling, Stirlingshire

511. I started my role as a senior social worker at HMP Cornton Vale in 1995. I remained in that post until 1999. I regarded the role as a plum job at the time. I was involved working as a senior social worker within a small team at the prison.

512. The numbers of women who were under the age of eighteen were quite small during my time at HMP Cornton Vale. It was the only place where young women could be placed if they weren't placed in one of the secure units in Scotland. I can't remember the exact numbers of prisoners who were under the age of eighteen, but they would have been small. I don't remember the establishment having a separate section for under eighteens. There probably weren't the numbers of young women placed at HMP Cornton Vale to justify that. I don't think that was unusual. I know that that was what happened at HMP Polmont at that time and would have expected that to happen in HMP Cornton Vale. Looking back, I don't think HMP Cornton Vale was an appropriate place to be placing women under the age of eighteen. I don't think it was a terribly bad place, but I don't think that placing them there was good for them.

513. It was an interesting role, and I met a lot of interesting people. I used to chair the mother and baby conferences and be involved in the decision-making process surrounding whether mothers could have their babies there. That was a multi-disciplinary panel who provided input and made the decisions. The only part of that process I felt uncomfortable with, and not appropriate, was that the governor sat on

the panel. I was against that because the governor would have been the route of appeal had it been decided that the women could not have had their baby with them in the prison. I raised my concerns but, unfortunately, was overruled by the governor. Separately, there was a suicide cluster that needed to be investigated. I remember that I was on 'Kaye Adams' on television discussing that.

514. I remember chairing a review where the group decided that a mother could have her baby in HMP Cornton Vale. The baby then came in and was reunited with the mother. Ultimately, the baby was taken off the mother. That wasn't because the mother couldn't look after the baby but because drugs had been found to be associated with the mother. I remember that I and another social worker had to physically remove the baby and return it to family members in Edinburgh. That was quite a traumatic thing for everybody concerned.

515. I do remember one occasion when there was both a mother and her daughter at the prison. I'm pretty sure that the daughter was under eighteen. They were both on remand and they shared the same cell. I thought that was quite a quirk of the system for that to have been happening at that time. I was quite surprised when a mother and daughter were allowed to share a cell. That was unusual and I was quite surprised that happened. Somebody somewhere had made the decision that it would be beneficial for the young person rather than artificially separating them. I remember that they had one of the bigger cells.

516. There was a rudimentary child protection framework operating within the prison. From memory there wasn't really an understanding or distinction made between juveniles and adults. I remember that the younger women would be mothered by the older female prisoners and thinking at the time that that was appropriate. In hindsight, that may have left open the risk of bullying between the older and younger female prisoners. I wasn't aware of anything specifically at the time that I was concerned about when thinking about the prison's approach towards it's juvenile prisoners. I didn't have any major concerns and there didn't seem to be terrible practice. From where I am now, with the experience and knowledge I have, I could pick holes in the systems and structures.

517. I interviewed a couple of women at HMP Cornton Vale as part of some research I was carrying out in 2015 whilst on secondment in later life to HMIPS. The research was looking at the impact of long-term segregation. One of the women came directly from Kenmure St Mary's. The women talked about the sensory deprivation they suffered because of their segregation and not getting enough exercise. I remember them talking about lying down so long that it had wasted their muscles and resulted in it being difficult for them to remain mobile in a normal way. They also talked about having trouble differentiating light.

Leaving HMP Cornton Vale / time spent at YOI Feltham

518. In 1999 I moved down to Hampshire and was a probation officer for a period of about six months. There was no working with children involved in that. I then got a job at Youth Offender Institution Feltham. YOI Feltham was in London and was the largest young offender unit in Europe at that time. I remember the establishment had a bad reputation at the time I joined. The Mubarek Inquiry had taken place about twelve months prior to me going there. That Inquiry surrounded the death of a prisoner who had been killed following a racist attack. I was appointed as a through care manager in the middle of 2000. I continued in that role until about 2002. I was the first social worker ever appointed to YOI Feltham. I was graded as a non-operational governor, which was the most junior governor role you could have, and I didn't have any operational responsibilities. However, I was still part of the management team.

519. One of the people who interviewed me for the post was a man called Robert Lake. He was one of my heroes and seen as an eminent social work director in Staffordshire Council. He absolutely understood the value of placing people from a social work background in prison establishments. He had previously worked in Staffordshire which was an area that had gone through various scandals and crises in their care sector. All of that culminated in The Pindown Inquiry, which was held between 1990 and 1991. The council had a reputation of being able to improve things a lot by about 2000. They started putting qualified social workers in roles in institutions which was quite a radical approach at that time. They were making these improvements because

they had seen what had gone wrong in their authority. I believe Robert Lake had been involved with all of that.

520. England had just introduced a new piece of legislation which was designed to create a seamless sentence. My job was to help introduce the system for Detention and Training Orders. The orders would last anywhere between six and twenty-four months. The idea was that the individual would serve half their sentence in a prison with the second half spent being closely supervised in the community by a member of the youth offending team. There was no one, at that time in YOI Feltham, who had a social work background, so my job was to link with the youth offending teams.

521. I remember that the youth offending teams were generally hostile towards the prison because of YOI Feltham's dreadful reputation. My role was to try and create a constructive and productive relationship between the prison and those teams. Looking back, there were some bad things that had been going on at YOI Feltham but, at the same time, there were some reasonable things going on there as well.

522. During my time at YOI Feltham we were inspected by HMIP. I remember I was given quite a hard time. Albeit I was one of the most junior members of the team, the inspection team were more interested in speaking to me than anyone else. I was the only one who was from a social work background, and they were interested in all the childcare stuff. Looking back, what was in place at that time at YOI Feltham was very thin. There was a child protection committee, in name only, and a very rudimentary child protection policy which wasn't really followed properly. There was no real due process or scrutiny of these things, and they were very much in the early stages of all of that. In the end, the inspectors realised that, playing with a weak hand, I and another colleague were trying to do what we could. They agreed with our approaches and found that our thinking was sound.

523. Reflecting back, it would be difficult for me to compare what I experienced at HMYOI Feltham with the experiences I had with YOIs in Scotland. You couldn't really compare HMYOI Feltham with anything in Scotland. HMYOI Feltham, at that time, was the largest young offenders establishment in Europe. It was much larger than any of the

Scottish YOIs. It also had a much larger proportion of black and ethnic minority young which meant there was a completely different dynamic. That was particularly the case further to the Mubarek incident.

Roles with Her Majesty's Inspectorate of Prisons

524. In 2002 a job as a prison inspector specialising in juveniles came up with HMIP. They were looking for somebody with a background in social work who understood the pressures of working within a secondary setting such as a prison. I had experience of working with children in care, so I was well suited to the role. I was successful in applying for the role and was appointed in 2002.

525. Fortunately, my background meant things all came together and I was appointed to the role with HMIP. I worked at HMIP for almost twenty years and left in about 2020. HMIP had an office in London where we would meet up once every two months. Apart from that, everybody was home based, working the equivalent of two weeks on, two weeks off. I started off as a main grade inspector and member of the juvenile team. I progressed to being the lead of the team and the lead person for juvenile work at HMIP.

526. Latterly, I led the police custody inspection team for eighteen months and finally worked as an inspector on the female estate. I travelled far in these roles and managed to work outside England. I was in Jamaica, Northern Ireland and the Channel Islands. Where we got the opportunity to get involved with developing policy work.

527. HMIP had, and has, a very highly regarded reputation worldwide. The findings we published were respected because we were confident that our judgements were sound. Many of the places we inspected just weren't good enough. Very often our recommendations would lie outwith the establishment with organisations such as local authorities, central government and other outside agencies. Because of that, although we were providing recommendations and findings to the governors in charge, it wasn't

always the prison's responsibility for making the mistakes that had happened and this helped to instigate change.

528. I think what HMIP were very good at was inspecting fairly and in a balanced way, gathering the information required, analysing and assessing that information and reaching balanced judgements. They would feed back their findings in a way that wasn't always palatable but was always fair and reasonable. I remember one of the chief inspectors saying that it wasn't our role to "bayonet the wounded on the field of battle" and I agreed with that. We always tried to provide encouragement and to motivate people.

529. Our role was to make constructive, realistic recommendations about how things could be improved. I think that we were pretty good at that and were able to make improvements. I could see absolute, clear evidence of that happening from the perspective of someone working in the juvenile team. I could track establishments and see the incremental improvements. Practice in the juvenile estate probably reached the highwater mark around 2010 when funding cuts began to result in a gradual erosion of standards.

530. Possibly the single biggest achievement I was involved with, which I would attribute more to my boss, was advocating to stop routine strip searches of juveniles in prison custody. That would have been stopped in about 2012 or 2013. The practice was done away with in England largely because of the lobbying done by HMIP. I am not sure what the present situation is in Scotland.

531. HMIP was a terrific place to work. I was working with very able, eminent people who had formerly held much more senior roles to mine in their careers. The standards were high, and people were really committed. I remember that the chief inspectors were phenomenally brave leaders. They were so able and could think and act very quickly. Working with people like that inevitably makes you raise your own game. It was important work and was a very satisfying environment to be within.

Secondment to Her Majesty's Inspectorate of Prisons for Scotland

Recruitment to role / role

532. By 2014 I was living in Scotland and working two weeks on, two weeks off, for HMIP based in London. I wanted to come home to continue my career and hoped to establish myself as a prison inspector in Scotland. Whilst there were lots of positives to working with HMIP, the travelling was having an effect. I asked Nick Hardwick, who was the chief inspector of HMIP at that time, if it would be possible to go on secondment to HMIPS. I don't think HMIP had done anything like that before, but he agreed to trying to get me seconded. Ultimately, that was what was arranged for 2015. My secondment was a straight transfer to HMIPS. It was intended to last twelve months but, ultimately, it lasted for eleven months.

533. I continued as a core prison inspector during my time with HMIPS. I was under the same conditions of service as I had been under with HMIP. It was agreed to be a straight swap of roles for me. There wasn't someone from HMIPS who went in the opposite direction. HMIP were big enough to absorb me being seconded for that year. I had hoped that I would continue to work from home in much the same way as I had worked with HMIP. However, upon getting the role I discovered that I was based in Saughton House in Edinburgh. I had to report in there there most days of the week throughout my time with HMIPS.

Staff structure

534. HMIPS's internal staff structure in 2015 consisted of one chief inspector. Below him was one deputy chief inspector. When I joined there was only one other core inspector as well as myself, who was an addition to the complement. The core inspector was a seconded role from the Scottish Prison System (SPS). There was one other core inspector over the time I was seconded other than myself. One replaced the other after a period of about six months. Beyond the inspectors there was an administrative team who provided assistance.

535. During inspections, serving governors were invited onto the inspection team. They would be called 'guest inspectors'. On a full inspection there may be a couple of guest inspectors. They would be involved with inspections onsite for one week only and be involved in the drafting up of the report. They'd get some time off from SPS to write up whatever they needed. It was part of the deputy chief inspector's remit to identify suitable candidates for those roles. Often, the deputy chief inspector would know them personally and the candidates viewed their appointment as a useful career opportunity. I think some people did it more than once.

Staff

536. David Strang was the Chief Inspector during my time on secondment. He held the role of Chief Inspector at HMIPS between 2013 and 2018. He was formerly Chief Constable of Lothian and Borders Police.

537. Jim Farish was the Deputy Chief Inspector during the latter part of my time with HMIPS. He was a really sound, fair minded man with a strong focus on human rights. He was an ex-governor of HMP Grampian but had run a few other big jails too. He was an experienced senior governor who knew the field well in Scotland. He is now retired from the prison service and works in the risk management sector.

538. Tony Martin was one of the core inspectors at HMIPS during the time of my secondment. He was there for the first six months. Tony Martin was a senior governor who had been seconded in. I was really impressed by him. He was a good guy. I remember him quickly grasping the human rights angles during inspections. His approach was really like my own. He is now the deputy governor at HMP Polmont.

539. Malcolm Smith was one of the other core inspectors at HMIPS during my time on secondment. He was drafted in from SPS on secondment after Tony Martin. Like Tony, Malcolm had worked his way up from the ranks and done well. He is now the deputy governor at HMP Glenochil. His approach was very similar to Tony Martin's.

540. Natalie Beale was a senior manager in HMIPS. She had been given lead responsibility for developing the new model for independent monitors during my time at HMIPS. I think Natalie reported directly to the Chief Inspector. She is currently the governor in charge of HMP Glenochil.

Training

541. I think there was a fundamental weakness in the guest inspector role. They were colleagues who were currently serving as governor grades in the Scottish Prison Service. They would have been identified relatively informally by the Deputy Chief Inspector or the existing core inspector from the Scottish Prison Service. They were brought in as a one-off for a single inspection and then returned to their home establishment. I think those guest inspectors that came in, understandably, saw their role as good for their career and CV. It gave them a broader experience and an opportunity to expand their repertoire.

542. The induction, training and orientation that guest core inspectors received was relatively limited. There would normally be a meeting in advance of the inspection to explain the process and procedures. They would be given a copy of the standards that would be used to inspect the prison, which was a sort of guidebook. There would be a matching between their interests and the area of the prison to inspect. During the inspection, help would be provided to the guest core inspectors so that they could organise themselves. That was really a bit of on-site coaching about what they needed to look at and how they should go about their tasks. If necessary, help and guidance was provided surrounding how they should write up their findings. Beyond that, there wasn't really anything further, formal or structured, when it came to training.

543. I was never comfortable with the use of guest inspectors. It held connotations for me with 'informal' and 'amateur'. I don't wish to come across as disparaging, but the inspectors at HMIP, who had been my peers, were employed and operating as professional inspectors. By professional I mean they were recruited and trained with a detailed induction and shadowing process lasting several weeks, along with close

supervision before they were allowed to operate on their own. They were also expected to function in a completely independent way.

544. The guest core inspectors were expected to report on treatment and conditions about establishments where they may previously have worked, or where there friends were already working. This also could often be places where they might expect to work in the future. In order for them to maintain the required level of objectivity and independence, I thought this was asking a lot.

Exterior organisations involved with inspections

545. Other organisations who had an involvement on inspections included Healthcare Improvement Scotland (HIS) and Her Majesty's Inspectorate for Education (HMIe). In 2015 the team was just beginning to also involve inspectors from The Care Inspectorate and the Scottish Human Rights Commission (SHRC). The involvement of the SHRC was a particularly welcome development and their particular expertise was something HMIP would have benefitted from.

546. The Care Inspectorate was coming on all the inspections undertaken by HMIPS. They would have therefore been involved with establishments that were prisons underneath the remit of HMIPS that housed under-eighteens, such as HMP Polmont. I'm not sure what their role was during the inspections. When I was there, their role seemed to be focusing on resettlement. They were interested more in the preparation for release side of things. I am not sure whether HMIPS allocated The Care Inspectorate a role and responsibility under what was broadly deemed 'safety' during its inspections of the establishments under its remit. From recollection, child protection would have been one of the areas that came under 'safety'. It was a positive feature of the methodology of HMIPS that they included representatives from other professional agencies.

Policies within HMIPS

547. I was quite heavily involved in developing child protection procedures for inspecting juvenile establishments down in England, but I didn't have that role in Scotland. I didn't have any involvement in, or responsibility for developing any policies so far as they related to the safeguarding and protection of children and the provision of education to children. During the inspections I was involved with, I would have made some comments in discussions surrounding the process of inspections and made suggestions based on how HMIP ran discussion groups. I would have discussed the way in which I was used to conducting those sorts of discussions. I felt, at the time, that those contributions, which were more comments surrounding process than methodology, were gratefully received.

548. HMIPS had responsibility for inspecting establishments that held under-eighteens, such as HMP Polmont. By the time I was on secondment with HMIPS the List D school system no longer existed. There were secure units such as The Good Shepherd in Bishopton, Kenmure St Mary's in Bishopbriggs, The Kibble in Paisley, Rossie School in Montrose and another one I don't recall the name of in Edinburgh. Those secure units were not inspected by HMIPS, they were inspected by The Care Inspectorate and Her Majesty's Inspectorate of Education.

549. The methodology used by HMIPS in 2015 to check how safe things were for under-eighteen-year-olds would have been the same as it would be for adults. HMIPS had no specific policies surrounding the inspection of establishments which held juveniles. The standards that were used to inspect establishments holding under eighteens would have been the same standards used for adult prisons. That applied to open, closed, high security or low security prisons, male and female. Those generic standards were adjusted and applied to the relevant setting. Within the generic standards would have been a chapter to make sure that people were held safely. That would be the area where standards for safeguarding would have featured, however, I don't recall that specifically being differentiated for under eighteen-year-olds.

550. There was a very important 2002 judgement in England called 'The Munby Judgement'. That judgement was made further to a judicial review brought by the Howard League for Penal Reform. Judge Munby found that The Children's Act 1989 applied in prisons and that local authorities had a duty of care to under-eighteen-year-olds. For England, that judgement raised the expectations of standards in penal settings in relation to its responsibility to care for individuals by virtue of their youth. There were important developments that flowed from that. As far as I am aware, that judgement didn't apply to Scotland in 2015 and I don't think it applies now. I don't think that things started to shift in Scotland until there was a recent drive to remove under-eighteens from HMP Polmont.

551. I don't recall the Munby judgement being discussed or mentioned at all during my time at HMIPS. It wasn't on the agenda. It was something that I was quite interested in because the lack of separation between juvenile and adult prisoners wasn't something that happened in England. I do remember being concerned in 2015, and now, that cohorts of sixteen to eighteen-year-olds were being held alongside a cohort of eighteen to twenty-one-year-olds in establishments in Scotland. Eighteen to twenty-one-year-olds are potentially a risky group to have mixed in with vulnerable sixteen-year-olds. In England, under-eighteens were always held in separate establishments and subject to different, higher standards.

552. When it came to education, the establishments in Scotland were inspected by specialist education inspectors from HMIe. They would come in under the banner of HMIPS, but they were autonomous from HMIPS in terms of how they reached their findings and their findings themselves. They would inspect their area and write up a report on their findings for that area. The standards they developed were the ways in which they wanted them. They had their own ways of establishing standards and how they found out whether those standards were met.

The process of inspections

553. HMIPS were responsible for inspecting all the penal establishments, custody facilities and, I think, escorts in Scotland. The process of inspection was the same for all the

establishments HMIPS inspected. There was a set of published standards that was available to inspectors by way of guidance for their inspections. I think those had been updated within the couple of years preceding me starting my secondment. I believe that an experienced, but retired, Scottish Governor was used as an advisor in developing these. I think new ones had just come out. They were human rights-based standards and they were quite detailed. All inspectors were expected to work to those standards. It was quite onerous for guest inspectors come in and pick this up quickly.

554. The inspection would start off with a presentation from the senior person on site. That would usually be the governor. That was really a 'pitch' about how well the prison was performing and what the aims were for the establishment in the future. The input given by governors in Scotland at the start of inspections was something that quite a lot of attention was paid to by the chief inspector and was usually referenced in the final reports. At HMIP those were things that wouldn't feature in the Chief Inspector's report. It would be taken as a given at HMIP that the governor was going to say something positive and present a positive picture. Following the initial presentation, the inspection team would then meet with the colleagues who were responsible for running the areas that they were going to inspect. There would be discussions about how we were going to organise our work and who and what we wanted to see.

555. There would already be information available that we had asked for in advance. That would sometimes be in the form of completed pro-forma forms being sent. Responses would have been sent to the team to look through. There would be statistics and other pieces of information. I'm not sure whether child protection was an area that was asked about as part of that exercise. I'd expect, were the inspection concerning HMP Polmont, pro-forma forms surrounding child protection would be included, however, I wouldn't be completely surprised if they weren't, as there seems to be no reference to this in published reports. Child protection is certainly something I would have asked about had I been involved with an inspection of an establishment that held juveniles.

556. The members of the inspection teams and process would be the same for all the inspections undertaken by HMIPS. The chief inspector was the focal point and would front up the reports. They would be the person who signed and took responsibility for

the reports. In practice, the chief inspector would top and tail the inspection and appear onsite at the beginning and the end. They would deliver the findings as soon as they were agreed and available. They wouldn't be involved in the nitty gritty of the day to day running of an inspection. It would be very unusual for them to be involved in any of the fieldwork.

557. The Deputy Chief Inspector had a more hands-on role than the Chief Inspector. They'd maybe deal with the more sensitive aspects of the inspection. One of those aspects was the new area of 'quality of leadership' that was introduced around the time of my secondment. It would have been difficult for a core inspector, who was likely more junior in experience, to make comments in that area. It would have been difficult, particularly for a guest core inspector, to make comment on a more senior member of staff in an establishment because they may ultimately be going back to work with the person they were commenting on in the future. Given the power imbalance, it would make it very difficult for them to be impartial or independent when making their comments. The Deputy Chief Inspector would have normally previously been a governing governor. They would have at least been on a par with the governor in charge at some juncture in their career and so would be easier for them, as a peer, to make potentially critical judgements about a prison's performance.

558. Reflecting back, there wasn't the same appetite to challenge critical findings in HMIPS as I had experienced at HMIP. I found that HMIPS were a lot closer to the inspected body. There wasn't the same separation or independence. In my opinion, HMIPS tended to operate more as a critical friend rather than as a fully independent inspectorate.

559. The remit of HMIP, as an independent, human rights-based, organisation would have been to report on treatment and conditions for prisoners. They would have done that without fear or favour. They would have not necessarily been concerned with the constraints and pressures that the governor and their staff were having to operate under. In contrast to this, HMIPS seemed to me, to some extent, to be interested in the constraints and pressures that staff were operating under. If HMIPS staff felt that outcomes were poor given the limited resources the prison had at its disposal, these

findings would have an impact on the final judgement of HMIPS. That wasn't the case at HMIP. HMIP would just report the evidence about treatment and conditions straight and leave it for ministers as to how the findings should be interpreted and dealt with.

560. The core inspector was the person who would organise the inspection and it was a busy week for that core inspector. They would be responsible for putting in place all the practical arrangements and setting things up. They would do all the preparation, make sure that they had a team assembled to do the work, schedule the meetings during the inspection and make sure that everyone knew where they needed to be.

561. There was quite a lot of work involved with ensuring that the specialist inspectors, such as people from The Care Inspectorate, SHRC and HMIe, had access, keys and everything else they needed to carry out their work. The core inspector did all those practical things alongside the bulk of the actual inspecting work itself. They would carry out inspection work over the course of the weekend as well as a night visit.

562. I thought it was good that HMIPS did visits at weekends, because it shed light on the out-of-hours experience. That wasn't something that HMIP ever did, but could have benefitted from.

563. There wasn't as much feedback provided on emerging findings as the inspection progressed at HMIPS as there was when HMIP during the course of undertaking their inspection. However, major issues, both positive and negative, would have been reported. There was usually a meeting held a couple of weeks after the fieldwork had been completed. It was something akin to 'a cold debrief' and would solely be attended by the chief inspector, the deputy inspector and the senior staff at the prison. The meetings were held to discuss what the findings should be and how things could be all pulled together. I never actually observed any of the debriefs in Scotland because core prison inspectors didn't attend. In England, core inspectors attended all of them along with the rest of the multi-disciplinary team, because ordinarily the rest of the inspection team would be invited along. The impression I got was that meetings following an inspection by HMIPS were more of a discussion, rather than a 'we tell, you listen', 'hot debrief' meeting that HMIP may have presented.

564. After a set period, establishments were provided with a draft copy of the report. We used to say to governors that we would be happy to receive any suggestions for corrections of factual errors, but analysis and judgement remained ours. Sometimes governors would provide additional evidence as part of their response to the draft. Establishments sometimes tried to challenge our analysis, but unless there was factual evidence to support this, HMIP would not alter their position. I found HMIPS were more inclined to make the suggested changes when asked.

565. I didn't think that there was the same level of respect shown to the inspectorate in Scotland by governors as was given to the inspectorate in England. In England, they would really struggle to accept the findings too but, because the process was so rigorous, respected and provided opportunity to respond, eventually they were usually accepted. I found the challenges to be weaker in Scotland and there was an unrealistic expectation about how positive we should be when presenting material.

566. At the end of an inspection HMIP would provide a draft copy of the findings for the governor to comment on. If there were any factual inaccuracies, we would accept them. Where we felt that was valid, we would make the necessary changes, however, the analysis and judgement remained ours. I felt that with HMIPS, when drafts were being commented on, sometimes the analysis and judgements were being affected by comments that the governors or the prisons were making. That surprised me and was different to my experience at HMIP.

567. I can only give one example of a challenge from a governor that I was asked directly to deal with. There was some evidence that prisoners had a fear of retribution if they made a complaint. I thought the evidence that led to our finding was quite clear. We had triangulated it, we had spoken to groups of prisoners, we had seen written evidence, we had spoken to staff and we made a clear finding that the system wasn't working as well as it should have. I can't remember exactly how we were challenged, but I was confident that our findings were clear and that we had reported in a reasonable and balanced way.

568. It was quite a concerning finding that I would have expected the governor to be worried about and, at the least, would have wanted to find more information about. However, the response provided was a bit dismissive and focussed on the wrong things. I would have expected concerns to be present in particular about 'fear of retribution', but that just wasn't what the governor was expressing.

The scheduling of inspections

569. When, or which, establishments were inspected, was at the discretion of the chief inspector and the deputy chief inspector. They were the ones who decided the programmes. I suspect they worked a year in advance and had an idea of the fixed inspections they wanted to do alongside creating space in the schedule for places where they felt the greatest need was.

570. There was a formula used that would determine when inspections would take place. I can't remember exactly what that was, but it was a similar formula to how HMIP worked. HMIP's formula was perhaps a bit more scientific because they were dealing with a larger number of establishments. It would be something along the lines of a full inspection once every three years. If there was intelligence, or there was a particular issue that had arisen, the date of the inspection could be brought forward. That would mean that a well performing establishment might not be inspected as frequently as a poor performing establishment.

571. On top of those inspections, there were further ad-hoc arrangements. I know that in either 2016 or 2017, HMIPS undertook a longitudinal study into HMP Polmont. I'm not exactly sure what that was. It was some sort of hybrid inspection that they used.

572. I think that some of the inspections were announced and some of them weren't. That was certainly the way that HMIP operated. There is always a need for unannounced visits. I'd expect the trigger for an unannounced inspection would be when risk factors were showing. HMIPS could be quite nimble in the way they operated because they were such a small outfit. One of the benefits of having seconded staff was that they

knew what was happening in the establishments. Secondees were keeping in touch with people in the field and would be aware of any problems arising.

573. Scotland is such a small place that it probably wouldn't be too difficult to pick up where something was going terribly wrong or if a worrying pattern of behaviour was occurring at a certain place.

The evidence ingathered during inspections

574. The evidence gathered during inspections would consist of many things. There would be information provided by the prison and written material relating to the conversations held between inspection team members and prison staff. There would be observations made by members of the inspection team of meetings amongst staff that took place in the prison during the inspection. There would be observations made by team members of typical behaviour on the wings during times when prisoners were unlocked. The team would even taste the food and have observations on that. You would just have your eyes and ears open all the time you were wandering about. You would be trying to absorb everything you could. One thing that we didn't do was roll checks to test for accurate time out of cell data. That was something we did in HMIP.

575. We would ask for quantitative data during our inspections. We would have to make a judgement call about the quality of the data we received. It was not unusual to be presented with glossy brochures which did not always accurately reflect what was going on in practice. In addition to quantitative data, we also requested qualitative material. One example would be asking for any written complaints that the prison had received over the previous six-month period. That was quite a useful area to look at. Reviewing complaints helped us to understand the culture of the establishment.

576. You can tell a lot from how a complaint is made, what it is about and what the threshold for making a complaint is. The response to complaints can tell you a lot about how efficient practice is. In England, if there was a concern that an establishment was taking too long to reply to complaints, we would use the existing procedures to make a complaint ourselves and wait to see what the response was. Through doing that

you could track very effectively that the complaints box wasn't emptied every night by the admin staff and whether they were getting sent to the right place. The actual responses to complaints could tell you a lot about how respectful staff were, how seriously they took matters and whether anything was done further to the complaints. That can be useful information that would be triangulated against other pieces of evidence.

577. HMIPS would have examined complaints but not in such a rigorous or detailed way as HMIP. I recall that during an HMIPS inspection, we did triangulate the evidence surrounding complaints. However, more generally I did feel that HMIPS often took the evidence at face-value without scrutinising it sufficiently. They wouldn't go to the same lengths as HMIP to verify and check the information given was accurate. An example of that would be statistical information such as 'time out of cell.' That would be accepted without scrutiny without possibly triangulating against other sources. That was a difference to HMIP's approach.

578. When thinking about the differences in approaches, HMIP was a much larger organisation which was longer established. I don't want to denigrate the people who worked at HMIPS as guest core inspectors, but HMIP had more professional inspectors. The guest core inspectors at HMIPS were talented, competent people but they simply weren't professional inspectors.

579. Part of the evidence gathered concerned the conversations the team had with the prisoners themselves. We would talk to prisoners who tried to harm themselves, ask them how they were treated and explore the associated processes and procedures. We would sit in on some meetings surrounding that. Conversations with prisoners were quite readily facilitated. You wouldn't entirely rely on any single source irrespective of their position. You would always be looking for two or three bits of evidence to back things up.

580. Quite often you would get the governor saying one thing, the staff saying another, then the prisoners saying something completely different. It would be the inspector's role to work out where the truth lay or how much emphasis to give each different

perspective. You'd just keep going back, keep talking to people and try to get to the bottom of things if you were getting differing views. Sometimes you just had legitimately different views. In those instances, you had the choice of whether to reflect that in the report or whether to take one view over another.

581. There would sometimes be staff present when we spoke to prisoners. It would depend on the nature of the people we were speaking to. If we were talking to a vulnerable person, who was maybe at risk of hurting themselves, we might want to talk to them privately. We would always make sure that staff were around in case something happened. The door would be left open on the cell, and you made sure to make an entry on the wing log of any concerns or whether everything seemed fine. We would have to be careful to document how things went with people like that. If it was in the evenings and there was an association where prisoners were out playing table tennis or generally larking about, you might get the opportunity to speak to a group of people. The HMIPS inspectors were all good at engaging with people. They would have to judge what they were being told and whether it fitted in with lines of enquiries they had previously been given.

582. At HMIP there would be someone who was allocated the role of inspecting contact with family and friends. We would spend quite a lot of time in the visiting areas observing what was happening. Before and after visits we would try and talk to family members about what their experience was, how they felt they were being treated and how they felt the person in custody was being treated. That was the main opportunity to speak to family members. I'm pretty sure that HMIPS also did that during their inspections as well. Over and above that, it was good to get the views of independent workers who worked on site who weren't employees. We would ask them what they thought about the culture, about the way they were being treated and about how they thought the prisoners were being treated. Psychologists that worked within the establishment would routinely be spoken to as part of the process. With regards to HMP Polmont, I imagine the internal social work team would be interviewed as part of that process.

Response to immediate concerns during inspections

583. If during an inspection, an inspector saw something that they were worried about, or it was a life-and-limb situation, they would immediately talk to the duty manager at the establishment. They would expect that it would be dealt with there and then.

584. If there were less immediate, enduring problems or weaknesses, that would be something the inspector would make sure to have a conversation about with their opposite number on the prison side. That conversation would be held as early as possible. A typical example would be "we're getting a lot of complaints from prisoners where staff were being rough with them during restraints. That's worrying for us, and it does seem a bit high for a place of this size. We can see your paperwork is a bit weak and you are not on top of it. I'm a bit worried about this, what is your first response?" You'd be looking for some sort of immediate response that recognised the situation and suggested they were going to deal with things after providing those comments.

Specific inspections I was involved with during my time with HMIPS

585. Over the course of my secondment with HMIPS we inspected three adult male establishments, HMP Grampian, HMP Addiewell and HMP Dumfries, and one female establishment, HMP Cornton Vale. I wasn't involved with inspecting a young offender institution or a prison that housed under-eighteens during my time at HMIPS. If I was, it wasn't something that was obvious to me. There might have been a small number of young people in custody at HMP Grampian. There were younger people at HMP Cornton Vale but, as far as I was aware, they would have been just over the age of eighteen. However, there was no bar on under-eighteen-year-olds being kept in custody at HMP Cornton Vale, so it is possible that there may well have been some present.

586. I was a core inspector on all the inspections I was involved with. I can remember that all the inspections I attended were planned, but I can't remember whether they were announced or unannounced. I don't remember any serious concerns being raised

about discipline and punishment, safeguarding or child protection at the establishments I inspected. However, I vividly remember concerns being raised surrounding access to toilet facilities at night and the complaints system at HMP Cornton Vale.

Visit to HMP Polmont

587. We visited HMP Polmont in 2015 but we didn't carry out an inspection there. I was keen to be involved with an inspection of HMP Polmont because they had prisoners aged between sixteen and twenty-one who were both convicted and on remand. I can't remember how the visit came about. The governor in charge was a person called Sue Brooks. She was a good communicator, who presented a very positive picture of her jail.

588. I think it was Jim Farish, who was the Deputy Chief Inspector, who organised the trip. He would have been a former peer of Sue Brooks. I'm not entirely sure what the purpose of the visit was because we didn't carry out any inspecting. I don't even remember visiting any parts of the jail. I spoke to Jim Farish before we went out and said that it would be good to have a look around. I don't know whether something had happened that meant we didn't get that opportunity to look around. I don't remember the detail surrounding that. In the event, our visit was more a 'keeping in touch' type of meeting than anything else.

589. The only persons present from HMIPS at the meeting was Jim Farish, me and the other core inspector, who would have either been Tony Martin or Malcolm Smith. All I remember happening was us speaking with the governor. Ultimately, the visit was frustrating for me because, albeit I was the most junior inspector on the team, I had a strong background in juvenile custody.

590. In my experience Polmont always had a rather poor reputation amongst social workers. Given my extensive experience of the juvenile estate I found it difficult to reconcile the very positive picture we were being presented with, along with what we know about how places like Polmont normally operate in practice.

591. Apart from visits earlier in my career as a criminal justice social worker, the visit I made to HMP Polmont was the extent of my involvement directly with the establishment, however, I have learnt further information since that time. I have had some contact with Linda and Stuart Allan, who are campaigners who are particularly critical about HMP Polmont. Their daughter committed suicide whilst serving a sentence at HMP Polmont. They attribute that to the way she was being treated in the establishment.

592. I have not seen those concerns highlighted in the same way elsewhere. An HMIPS report of an inspection carried out at Polmont in 2018 described it as a 'Leading Edge Prison', which was despite findings by specialist inspectors that attendance at classrooms typically only ran at around 50% and healthcare provision was assessed to be poor. These findings of significant weakness seemed inconsistent with the headline statement.

Investigations into abuse during time on secondment

593. There wasn't a specific definition of abuse at HMIPS. I think the common understanding of abuse would have been used. I wasn't involved in any investigation on behalf of HMIPS into allegations of abuse or ill-treatment of children at any of the establishments I inspected. Nor was I involved with investigations into inappropriate behaviour of staff or others towards children.

Research undertaken during secondment

594. During my time on secondment, I undertook some research which involved interviewing twenty-three of the longest serving prisoners who were in segregation in Scotland. They were in what was called 'deep custody'. I was asked to undertake the research by the chief inspector at the time, David Strang, and the deputy chief inspector, Jim Farish. I think one of the SNP politicians at that time had been keen to get information about the topic and had been repeatedly asking HMIPS to do something about it. I think that was what may have triggered the request. I think I was asked because I had some background in social research.

595. Most of the people I interviewed were in their early to mid-thirties. They were all persons who were completely disengaged, disaffected and difficult people. They were all problematic prisoners for the Scottish prison service to deal with. Some of them had been in segregation for years. The prison system just didn't know what to do with them. My impression was that they were broken people who had repeatedly been knocked down by the system over the course of their lives. I remember a couple of them were in poor physical and mental condition because of the impact of being segregated for such a long time. At times, it wasn't easy research to complete.

596. I was happy that there were prisoners amongst those I approached who wanted to contribute. Only two or three people refused to see me. One of the questions I asked all twenty-three prisoners was whether they had been in residential care over the course of their childhoods. I remember that half of the people I interviewed not only said that they had been in residential care but that they had also been in secure care as teenagers. They were subject to the deepest levels of custody that could have been imposed on them when they were that age. I remember being surprised by that finding.

597. I remember asking all the prisoners "when things have been going well for you, what has made the difference?" The most common answer was having access to somebody, from whatever organisation, who went the extra mile. They all said that the difference was meeting people who listened, took them seriously, did more than they needed to do and stuck with them. That came out quite strongly in my research and is a finding that has been expressed separately elsewhere in other research since.

598. I think it was an interesting and somewhat useful piece of research. I no longer have access to my report. It was the property of HMIPS so I couldn't keep it. I submitted my report to David Strang in 2015. I understand that he looked at it alongside Jim Carney who was part of the research department at SPS. The research did not, ultimately, get published. Although I heard nothing directly, I understand that David Strang and Jim Carney thought that the research was interesting but didn't feel that it could be used. I was disappointed that my findings weren't investigated further.

599. A year later, I asked an expert on segregation at Oxford University to look at my research. Her name was Sharon Shalev and she was attached to the faculty of law. She felt that there was useful stuff in it and thought the findings surrounding the high prevalence of former secure care residents amongst the population of prisoners who were in segregation particularly interesting. I don't know whether HMIPS is likely to have retained a copy of the research.

600. HMIPS have just published a thematic review of deep custody. It is a really good piece of work. HMIPS consulted with Sharon Shalev when producing the review. It is interesting because it has been published under the auspices of HMIPS but the two principal authors are University of Edinburgh researchers. This piece of research is a lot more polished than mine and has provided some highly relevant and challenging findings.

601. Shortly after I started my secondment, David Strang told me that he would like to make a comparison between the methodology of HMIP and HMIPS. He named a senior official who he said would be interested in this and "put me on notice" that I would be expected to carry out this task. I think that was Neil Rennick who was the director of justice. He would have been the chief inspector's line manager. David Strang didn't press me on that, and that exercise was never undertaken.

Comparisons and contrasts between Her Majesty's Inspectorate of Prisons and Her Majesty's Inspectorate of Prisons for Scotland

602. Most of my reflections are formed further to my experiences and observations during the time I was seconded to HMIPS over the course of 2015. However, I have also kept abreast of published reports and other published documents by HMIPS. I have an interest in the area, so I have a look at anything that comes out. I would say that I am reasonably well informed and well placed to form comparisons.

603. I appreciate that some of the examples do not directly apply to the care of under-eighteens and I think HMIPS has improved its approach since I worked there, in

particular with the recent adoption of prisoner surveys along with the use of academics to conduct specialist thematic work.

Scale

604. England is many times larger in terms of establishments and the size of its inspectorate. HMIP would have roughly had about one hundred and twenty prisons to inspect. HMIPS was noticeably smaller than HMIP and there were about fifteen prisons in Scotland at the time I was on secondment. Within those establishments were places, like HMP Polmont, that housed juvenile offenders. For a more accurate look at the scale of HMIP, there were comparative exercises undertaken in England by the audit commission around twelve years ago. They carried out a review of the police inspectorate, the probation inspectorate and the prison inspectorate in terms of value for money and amount of output. HMIP came out very positively. That review might be a useful starting point to undertake a comparison with HMIPS. Another good source would be to compare the annual reports of HMIP and HMIPS. In terms of relative outputs, those reports would provide details about an overall budget, staffing levels and the number of publications generated each year.

Human rights

605. During the time I was at HMIPS, they started to involve individuals from the SHRC when inspections were undertaken. Involving individuals from the SHRC was quite an innovative step at that time. That was something that HMIP didn't do and was a positive feature of the practice operated by HMIPS. It gave a strong human rights strand to the inspection process on site. I can remember lots of ethical debates about human rights. What struck me was that those sorts of debates were very much at the beginning stages. They weren't debates that conclusions were being drawn upon. I remember there was an issue about a trans prisoner at HMP Cornton Vale in 2015 and the human rights person was helpful. However, at that point their role wasn't developed enough for HMIPS to form a settled position on many of those sorts of matters.

Approaches towards establishments holding under eighteens

606. The standards that HMIP used were called expectations. They had different versions for different types of establishments. They had a separate small book of expectations for juvenile establishments because of the different needs and nature of juveniles in custody. They had a separate one for women, a separate one for adult males, a separate one for immigration centres, a separate one for police custody and so on. HMIPS had not developed a specific set of standards for use with under-eighteens. As far as I remember, HMIPS used a standard generic set of standards to apply to all penal settings. The same methodology was used for HMP Polmont as it would be for HMP Barlinnie. I would question whether sufficient emphasis was always placed on the specific needs of juveniles as a result of that.

607. At HMIP there would have been a lot of questions surrounding child protection. There were questions on procedures, what the safeguarding arrangements were, what was the independent scrutiny and what would happen when specific things happened. We would be asking to see things like child protection logs. There would have been a minute investigation into safeguarding as a key important area. I can't remember the specifics of how inspectors approached things at HMIPS in that regard.

608. HMIP had a specialist juvenile team that covered all these establishments. I was latterly the leader of that team. You would calibrate your approach to make sure that you were able to engage with young people. You would, for example, be more tolerant and patient where there was naughty behaviour than you would be with an adult. There were different ways and means of ingathering information when working with young people. I don't know how geared up HMIPS was when dealing with young people in a place like HMP Polmont. I didn't inspect HMP Polmont, but the evidence ingathered would be the same as other establishments. I couldn't comment on how much the team would adjust its approach when dealing with a younger age group. There probably wouldn't have been that many on the team who were specialist young people workers. They would have been more likely used to dealing with adult males.

609. HMIPS didn't have responsibility for inspecting the secure units that were in Scotland in 2015. That oversight fell to The Care Inspectorate and HMIe. I think it would be interesting to compare the way in which The Care Inspectorate and HMIe's approached inspecting child protection procedures with the way in which HMIPS inspected its establishments that housed under eighteens. I would envisage that the approaches would be very different. One of the things that HMIPS should be given credit for recently is that they have been very supportive of the steps being taken to try and remove under-eighteen-year-olds from HMP Polmont. Albeit that wasn't something that was on the agenda in 2015, over the last couple of years they have been very vocal in supporting that. That should have happened a long time ago.

Inspection of education

610. Education is a very important part of the inspection process. It is trumped by safety, but it is nevertheless a really important element to be inspected. HMIPS worked with other specialists' inspectorates, such as HMIe, when inspecting establishment. In England, HMIP worked with the Office for Standards in Education (Ofsted) when inspecting the educational aspects of the establishments it was inspecting. Reports would be drafted that would be pooled together into one final draft report.

611. The way HMIPS approached things was very different to HMIP. In England, it was very much a round table debate involving all of the partner inspectorates. Ofsted were completely autonomous and there would frequently be some quite strong, challenging discussions about how an overall judgement should be reached. An example of this was 'time out of cell'. In England, this area was included in the same category as education and there was an overall judgement because of the way the methodology was designed. Sometimes, the time out of cell would be good and the quality of education would be bad or vice versa. It could take quite a long time and a lot of discussion in those circumstances to reach a compromise or a fair and balanced decision about which element should be given greater emphasis.

612. In Scotland, the sorts of round table discussions I experienced between HMIP and the Ofsted equivalent didn't take place. The education inspectors, who were confident,

professional people, would be clear about what they were saying. They reached their conclusions about the areas they were responsible for on their own. However, I don't know whether their views had an ultimate impact on the final judgement or strapline. That was less clear to me.

613. A good example of that would be the inspection of HMP Polmont that was carried out in 2018 with the report being published in 2019. That report states 'HMP YOI Polmont is a leading-edge prison, clearly demonstrating the SPS investment in attempting to break the offending cycle at an early stage through evidence-based practice.' Those were the Chief Inspector's comments made in the initial summary. However, in that same report, under the healthcare section, this area was graded as poor. The report found that the percentage of young people who were able to attend education was below half and HMIe were critical about that lack of attendance. That finding didn't feature prominently in the summary of the HMIPS report. These sort of unambiguous findings would have been treated differently by HMIP. Had those two factors been published in a report by HMIP in England, the strapline would have been very different. In my opinion, the establishment could not possibly have been described as a 'leading edge prison.'

Background of staff

614. HMIP employed professional inspection staff and is a very well led organisation. The chief inspector could not be someone who had previously been a governor. That was a stipulation that was in place to protect and maintain the independence of the organisation. HMIP have had a series of eminent, high profile, extremely capable figures in that role, people like Nick Hardwick, Anne Owers and Peter Clark. They attract a lot of publicity and attention and their views are influential.

615. HMIP made sure there was a blend of professionals as part of the teams from various backgrounds. There were psychologists, social workers, specialist healthcare workers and probation officers alongside persons brought in by Ofsted to look at the educational side of things and colleagues from CQC to scrutinise healthcare. HMIP consciously have limited reliance upon seconded governors. There were people part

of HMIP who were employed by the prison service for a couple of years to update and blend their knowledge and skill base with other inspector colleagues. However, HMIP made sure that there weren't too many people in the team like that. They felt that a predominance of seconded governors might result in an actual, or perceived, lack of balance or independence being given during the inspection process.

616. One of the first things I noticed at HMIPS was that there was a heavy reliance on seconded staff. Prior to my arrival all the core inspectors were seconded SPS staff. Two of the key people involved when I arrived were the Deputy Chief Inspector, who was an ex-governor in charge, and a core inspector who was my grade, who had formerly been a senior governor in the prison service in Scotland. Those staff members were being asked to comment on places that they may previously have previously worked in and to sit in judgement of people they had previously worked with, for and over. On reflection I think this created quite a tricky tension and potential conflict in the role of the Deputy Chief/core inspector.

Focuses and standards

617. From my own observations, I believe that in 2015 treatment and conditions for Scottish prisoners were generally superior to those that prisoners in England and Wales experienced. The standard of prisons in England are probably lower than those in Scotland but the impact of HMIP's inspections on prisons is, in my opinion, stronger than HMIPS's.

618. At HMIP we had high expectations of standards. In times of austerity, we resisted the temptation to accept lower standards. That was a conscious decision made by the chief inspectors. They all felt that it was important to maintain high standards and didn't want to buckle in the face of austerity. When governors complained about not being able to do what they were being asked to do by HMIP because their budgets were being cut, our argument was that if we lowered our expectations in terms of standards then their budgets would never increase. We wanted to maintain our high standards to hopefully provide leverage for the governors to increase their budgets to get the things that they needed. I think our approach worked.

619. I think that without our chief inspectors taking the stances they took, and maintaining the standards they wanted, budgets in prisons in England would have likely remained even lower. The light would not have been shone on the prisons we inspected, and change would not have happened. HMIP had a powerful, positive influence on drawing attention to things that were happening and making arguments for how things might be improved.

620. In my opinion HMIPS sometimes paid too much attention to the constraints that governors operated under, such as operational difficulties and high staff sickness. These are important issues and need to be addressed but they should not deflect from reaching clear judgements about treatment and conditions.

Methodology and data

621. The methodology employed by HMIP is highly rated and has been highly refined over the years. It was constantly self-improving. Top research people looked at it and evaluated it. It was scrutinised on a very regular basis with feedback being taken from stakeholders on an annual basis. That feedback was constantly acted upon. There was a lot of high-quality information ingathered as part of HMIP's inspections. That was used to inform future inspections. One of the most important aspects of HMIP's methodology was the active use of surveys. For every inspection there would be a detailed survey undertaken amongst the prisoners asking them about all different aspects of their experience. There was a very strong strand of evidence surrounding 'the user's voice' available to HMIP for every main inspection that they carried out. There was a huge bank of data created that allowed academics to, in turn, produce research to develop deeper understanding surrounding prisoner experiences.

622. Prisoner surveys formed an important part of HMIP's inspections. There was quite a lot of take up from those prisoners we surveyed. The return rate was between 80% and 90% for juvenile establishments. That was testament to the skills of the researchers undertaking that work and the refinement of the methodology that they used. The researchers would engage with prisoners on an individual basis and talk to

people. If English wasn't the prisoner's first language, they would immediately make arrangements for translators to be made available. Prisoners with literacy issues would automatically be given help.

623. On top of the information we obtained through the survey work we obtained further data. Examples of data ingathered included fights, assaults, time out of cell, serious incidents, suicides, self-harm and so on. All that data would be independently ingathered and measured. All the data we analysed wasn't taken at face value and would be triangulated against any other evidence available. Ideally, you were looking for three points on the triangle. You'd be looking for statistical data, observation and conversation so that you could form as clear a judgement as possible. That was the standard approach that we adopted.

624. At HMIP, there were several different important correlations that inspectors could do to help them out with their inspections. That helped inform inspectors work out whether progress was being made from a prisoner's point of view and to see the journey the establishment had travelled. Our methodology allowed us the ability to create an independent, objective account about how prisoners were treated and the conditions they lived within. Through all the work we did we made reports that were authoritative, credible and influential. I think that resulted in people taking them and us seriously. Researchers came from all over the world to see how HMIP operated. The human rights organisations, mostly, rated us highly and regarded us as independent.

625. HMIP routinely requested and were supplied by prisons in advance with information about things such as fights, assaults, suicide and time out of cell. My experience in Scotland led me to believe that this information was not as easily available to HMIPS. This sometimes made it difficult to reach accurate judgements about performance in certain areas.

626. In my experience, HMIP would be more likely to test out the information we ingathered from establishments against what we were seeing and what prisoners were telling us. There was more of a tendency to be curious and to scrutinise information and to

question its quality and reliability. There was a tendency at HMIPS to accept information at face value. When information was given to the core inspectors there was a level of trust present. The core inspector would accept that the information was bona fide and legitimate. They would treat it, more or less, as factual.

627. Time out of cell is a classic example of where different findings can be made in circumstances where you don't triangulate the information you have access to. If you ask the governor about time out of cell, they are going to give you a statement about what he or she thinks is happening. That perception is probably based on material of what they have been told is happening. HMIP would routinely carry out an unannounced roll check at a set time during a busy part of the day to establish how many prisoners were locked up in their cells. It would be unusual for the findings from the roll check to tally precisely with the information that the governor had provided. That kind of double checking was not routinely part of HMIPS's methodology.

Historical and geographical comparisons, recommendations and the traffic light system

628. All the information available through the surveys and other data that had been ingathered allowed HMIP to benchmark for historical comparisons. There would be a full inspection undertaken every three years for a large establishment and the information was available to compare prior inspections and similar establishments and places that were maybe within the same geographical area.

629. HMIPS's methodology and access to relevant data made it difficult for them to make comparisons on how things had previously been. It was almost as if each new inspection was starting again from the beginning. It was difficult to get a sense of where the benchmark was. The methodology I witnessed at HMIPS wasn't as refined or as developed as the methodology HMIP used. That made it much more difficult to assess the journey travelled, or progress made, by a particular establishment. Recommendations weren't being used effectively. There was very little comparison between current inspections and what had previously taken place. That was largely because the data just wasn't available.

630. HMIPS were moving away from recommendations during my time there. There was a reluctance to use recommendations, which was the orthodox approach when conducting inspection work. I remember them talking about the importance of using 'improving language.' A traffic lights system had been introduced which graded findings across various areas. In my opinion, the removal of recommendations and the introduction of the traffic light systems fed into the idea of HMIPS being more akin to a 'critical friend'.

Independence of chief inspectors and relationship with senior officials

631. HMIP's role wasn't to tell the prisons or government what to do but to lay out what the objective findings were. It was for prison governors to form a view upon whether they agreed with the recommendations, how much of a priority they assigned to the findings and what they did with them. HMIP was necessary 'grit in the machine'. We didn't have a comfortable relationship with government. There were examples of chief inspectors having their terms shortened because they were in dispute with the Home Secretary. The chief inspectors were brave, bold and did what they felt was right. David Ramsbottom is a famous case. He fell out with Jack Straw and left early. I saw Anne Owers challenging the government officials during inspections. I remember Nick Hardwick being pressurised by Chris Grayling MP to amend reports and findings and he resisted. From my humble position, it was clear to me that the chief inspectors I worked under never buckled under the pressure.

632. I know that in the past HMIPS had very forthright chief inspectors appointed. Clive Fairweather springs to mind. He was an ex-military man who spoke very vociferously about poor conditions. Hugh Munro is another. I think he is currently a non-executive board member of HMIPS. By 2015, my own personal view is that there wasn't enough of a separation between the inspectorate and the inspected bodies in Scotland. That was partly due to there being a dominance of ex or current prison service staff at HMIPS. That ran from the deputy chief inspector down. They were not, as was the case with HMIP, 'grit in the machine'. HMIPS acted more in the role of a 'critical friend' rather than an independent human rights-based inspectorate that was responsible for

creating a public record about treatment and conditions. In my opinion, there was a tendency for the relationship to become too comfortable, close and consensual.

External scrutiny of HMIP and HMIPS

633. HMIPS were in the process of setting up independent monitors during the time I was on secondment to them. They were ultimately introduced in 2015. The monitors were intended to monitor all the establishments that HMIPS had responsibility for inspecting. That model was intended to replace the local visiting committees. There had been mixed views about the local visiting committees in the past. It was quite a big shift for HMIPS and quite controversial at the time. I think the change may have been driven by financial decisions but I am not sure.

634. Theoretically, the new model was seen as a way of trying to improve the level of scrutiny on establishments, to make sure that prisoners' human rights were upheld and that their life in prison contributed to their rehabilitation. In addition to the once every three-year, deep-dive, focused inspections, they would have several well-informed, appropriately curious lay volunteers who would go into specified allocated prisons on a more regular basis. That process was intended to create a more frequent presence to ascertain what the temperature was in the prisons at any one time. The information gained through independent monitoring would be then combined with the information produced by the inspections under the umbrella and leadership of the deputy chief inspector. It was intended to provide more in-depth information to form judgements about how effectively, or not, the prisons were operating.

635. Natalie Beal, who was a senior manager at SPS and reported to David Strang HMCIPS, was leading on this project. Andrew Coyle was the person who HMIPS went to for advice surrounding how that model should be introduced and implemented. Andrew Coyle was the doyen of prison governors in the 1980s and 1990s. He later went down to England to become an academic.

636. During my secondment, I saw the model being tested out on governors. Their views were sought on how useful it would be, how workable it was and what they thought of

it. During that process I was quite surprised to see how little attention was being paid to seeing what the public would think about the model. It seemed to me that the key stakeholder, from HMIPS's perspective, were more the prison governors. It was clear to me that what should have been happening was that the public should have been the people who were being asked the questions to begin with. They should have been the number one stakeholder. I raised this issue in discussion with colleagues at HMIPS but was unable to convince them. I don't think the model had been thought through in these terms.

637. Up until 2022 there were quarterly reports published by the independent monitors. I understand that the quarterly reports are no longer being published and they're going to combine them into an annual report. Reflecting on what I saw then and what I have observed since, I think the outcome of the independent monitoring scheme has been disappointing. The regular published reporting that I have reviewed tends to be bland, very repetitive and quite deferential in relation to their views of prison governors. The reports are largely descriptive and don't provide much analysis or judgement. It is very difficult to establish any impact or any progress that the new model has made from the published material.

638. I think it would be useful to have an independent review and evaluation of the effectiveness of the independent prison monitor model and to compare it to what went previously. It has been in place for eight years and, as far as I am aware, there hasn't been an independent evaluation. There is a management board and, although chaired by a sheriff, it is primarily made up of existing or retired government officials. There is not sufficient external, independent representation. It could be that there are arrangements for a review in place but that isn't something that I have seen or am aware of.

Differences in practice when disclosures were made

639. HMIP always carried out surveys during inspections of juvenile establishments. We would ask the young people how they were treated and the conditions they were living in. Most of the questions were fixed but space was provided to make any comments

they wanted to make. We would always get complaints about various ways in which they were treated. There were times when we would get serious complaints and comments surrounding historical abuse. Typically, the complaints surrounded unidentified bullies.

640. The researchers would look through the surveys and identify concerns that needed following up. Those concerns would be passed to me, and I would look through them. It was a confidential survey but there was a caveat that in the event of disclosures of a serious nature I would have to carry that out. I would sift out anything where there was an indication that a young person was immediately at risk of anything. I would then speak to the deputy governor about what had been disclosed.

641. It wasn't for us to tell those running the establishment what to do but I would ask them what they were going to do. What should happen then is that the establishment's procedures should kick into place. That would usually involve background checks being undertaken on the alleged perpetrator and further enquiries being undertaken before they spoke to the young person. If there were social workers onsite, they would be a good person to undertake that role. It may be a staff member who the young person had a particularly good relationship with. Quite often, the young person would be annoyed that their confidentially had been breached and would retract what they had said. Regardless of that, HMIP would continue to pursue the matter until we were satisfied that the young person was no longer at risk. That might involve someone being moved out of the establishment.

642. If it was historical allegations or the allegation was unclear, the establishment would be expected to undergo its own child protection procedures. What should happen is that a local authority designated officer (LADO) should be allocated and appointed. If their appointment was necessary, they would liaise with the home to investigate its procedures. If it was a current and present risk the LADO might co-ordinate a strategy meeting with someone from the establishment present and possibly individuals from the police and the local authority. If things were getting to that stage, HMIP would be interested in scrutinising what was happening and how able the establishment was at putting their policy into practice. We would be interested with how often they were

doing what they were supposed to be doing when they received a concern. That allowed us to test the establishment's procedures and enabled us to gauge how robust they were.

643. I am unclear as to what was done when young people made disclosures to HMIPS during their inspections. Likewise, I can't comment on what the procedures were when disclosures were made in prisons that housed under eighteen-year-olds in Scotland.

Leaving Her Majesty's Inspectorate of Prisons for Scotland

644. I was hoping that my role with HMIPS would turn into something more permanent. Towards the end of my tenure, I asked HMIPS whether I could be mainstreamed. My impression was that HMIPS were happy with what I was doing because I was bringing in new ideas and was a good team player. I also already had a successful track record down in England with HMIP.

645. David Strang told me that HMIPS would be happy to have me, but I would need to go through the standard interview process. I said that I wasn't willing to do that because I felt I had already shown HMIPS what I was able to do and was already an equivalent senior grade. However, David Strang wouldn't agree to dispensing with the due process. I think the Deputy Chief Inspector and the other core inspector may have been disappointed with my decision. I was quite unhappy with David Strang's position and wasn't prepared to be put through what I regarded as an unnecessary recruitment process.

646. In the end, HMIP came back to me and asked me to return down South to do a job for them before the end of my secondment. I ended up leading the police custody team there for eighteen months. I started that role one month before my secondment was due to finish in 2015. I was disappointed that I couldn't continue in my role as a core inspector with HMIPS. The people I was working with were good colleagues. I thought they were trying their best but, to some extent, they were constrained within the framework they were working.

Career after leaving Her Majesty's Inspectorate for Prisons in Scotland

647. I worked for another four or five years in various senior roles within HMIP before retiring in 2020. After that I did six months working as a field social worker in North Lanarkshire. This didn't suit me and I then did eighteen months with The Scottish Association for Mental Health (SAMH) working with homeless sixteen to twenty-five-year-olds. I enjoyed that but left due to a disagreement on policy surrounding taking young people who had special needs out in the community. I kind of got a bit on my high horse and resigned. I felt strongly about the issue I was arguing for. I have recently been appointed by Quarriers in a similar sort of role as the one I had at SAMH. I started that role in July 2023. It's two days a week and it is again working with homeless young people.

Reporting to police / criminal proceedings

648. I have never provided statements to the police in connection with any of the establishments I have been attached to. I have never given evidence in relation to abuse of children or young persons in my care. I have given evidence in FAIs in connection to deaths at HMP Cornton Vale. Those deaths occurred in the mid-nineties and were not to do with prisoners under the age of eighteen. Following the death of an inmate at Feltham HMP&YOI, I also gave evidence at a coroner's inquest in London in 2001.

Records

649. I haven't held on to any records in connection to any of the establishments I worked. All the organisations I worked for had strict disposal policies. I remember that HMIPS operated a particularly strict policy with regards to records.

Resources that may be helpful to the Inquiry's work

650. I can highly recommend a book that I think the Inquiry should be aware of. It is called 'A Glasgow Gang Observed' and is written by James Patrick. James Patrick is a

pseudonym of the real author's name. Nobody knows his real identity, but he was born in 1943. I suspect he was a Scottish academic. I would be fascinated to discover his real identity. He was a researcher in the mid-sixties who was also a teacher in a List D school. James Patrick joined a gang in Maryhill in Glasgow for four months in the mid-sixties. He wrote an account as a participant observer in line with what a lot of the classical American criminologists were doing at that time. His account provides all sorts of insights and information about what was going on. James Patrick was involved with the gang right up until the stage when he became compromised. The gang members were wanting to get him involved in some serious criminality. The account is so much better and real to me than the accounts Jimmy Boyle provides. It is a more accurate and realistic picture of what life was like growing up on Glasgow estates and gang culture. I think it is a reliable account, is beautifully written and provides a good slice of social history that may be helpful to the Inquiry.

651. Another publication that would provide some useful background is called 'Children Behind Bars' by Carolyne Willow and was published by Policy Press in 2015. Carolyne Willow is a very experienced child protection social worker. It's the best book I have ever read on children in custody. It's based on the English experience and talks a lot about secure training centres. It makes quite a lot of reference to HMIP and is on occasion critical of them. Carolyne Willow is a radical reformer and an abolitionist. She felt that HMIP didn't go far enough in their criticism sometimes. She is very keen on human rights and what she says is very much in line with The Scottish Government's commitments to removing under eighteen-year-olds from custody and stopping the use of restraint on children.

652. There are some reports and research that should be of assistance to the Inquiry's work. The first was around during the time I was at Dock Street, 'Another kind of Home' by Angus Skinner from 1992. Angus Skinner was a former senior social work official at the Scottish Office. He understood all about residential childcare. He explained in his report when residential childcare could be used and how it could be considered as a good positive option for older children. He understood that residential childcare wasn't going to meet everybody's needs but found that it was something that may be appropriate particularly for older children on a voluntary basis. I think he

makes that case well in his report. The other report that I have no doubt will be of assistance to the Inquiry is the findings of the independent inquiry into abuse at Kerelaw by Eddie Frizzell. He was a former chief executive of SPS. He was a senior civil servant at the time of the inquiry. What I liked about his report is that he not only uncovered the abuse that occurred in Kerelaw but, at the same time, highlighted how difficult the task was when looking after children in a residential setting.

653. Andrew Coyle trained as a priest before joining the prison service in Scotland. He went on to be the governor at a number of prisons in Scotland. In the late nineties he went down to England and was governor at a couple of prisons. He then entered academia where he became an Emeritus Professor of Prison Studies at the University of London. He became known as a world expert on human rights in prisons. He wrote a book in the early nineties called 'Inside: Rethinking Scotland's prison' published by Scottish Child. I used a lot of his material when I wrote my dissertation. He was consulted with pretty heavily during the development of independent prison monitors in Scotland. He is seen as the doyen of Scottish prison governors and is very highly respected. He may be a useful resource for the Inquiry.

Helping the Inquiry

654. I have been lucky with the roles I have held over the course of my career. They have all been interesting. When I reflect on how I was when I began my career at the Kibble, I realise that I was a complete amateur. Although I was well intentioned, I had no training or experience. As time went on, I learnt more and became more confident. I started to understand things better because of my added experience and, most importantly, became better with dealing with people. I started to feel that I could make things better.

655. People tend not to be interested in the detail of what happens and happened unless they were involved with organisations that provided residential childcare. I have held an interest in residential childcare throughout my career and have continued to try and

keep abreast of developments. I like to keep up to date with the press and what has been reported. I've written letters to newspapers at various times and reviewed books on the subject. I've always been interested with how the debate has developed. There has been so much published over the years. As far as I am aware, there are over twenty-five reports about child abuse in homes alone.

656. I have keenly followed the Inquiry and read the reports that have been published so far. A lot of the people the Inquiry have spoken to are those who were regarded as 'heavy hitters' by those working in the sector in the eighties. At that time, I was very distanced from those individuals in terms of where I was in my career. It has been interesting reading their reflections and observations on things. A lot of the things that I set out below have been said before by people much cleverer than me. However, I do think they are worth repeating because a lot of what has been said certainly chimes with my own experience. I don't think PHDs are needed, or further research is required, to find out what does and doesn't work when it comes to residential childcare, secure care and the care of juveniles in prisons. A lot of it isn't rocket science and would be simple to understand and put in place.

Examples of projects and schemes that have had a positive impact on children and young people in residential, secure care or the prison system

657. There are two projects and schemes that I am aware of, and had experience with, that I think were of particular benefit to young people who either had the potential to end up in the prison system or were already in custody within the prison system. I highlight them here as I hope that the Inquiry can perhaps learn the positive benefits of both examples.

658. The Freagarrach Project was established in 1995 and ran until 2000. At that juncture it was diluted. It was a project run by Barnardo's with bases in Polmont and Alloa. The project ran alongside Central Regional Council and Central Police when implementing its aims. It was funded by The Scottish Office and was well resourced. The project targeted persistent young offenders and used a system that had been developed by Central Police to identify them. There were five quite serious offences

that were targeted. The project was what you would call a demonstration project. It's role was reminiscent of the youth offending teams that had been established in England. It operated like a junior probation service that worked intensively with young people who were at risk of coming into custody. The aim was to prevent them from coming into the prison system.

659. The teams were multi-disciplinary and based in the community. They involved teachers, social workers, psychologists, I think police officers and other specialists. The varying backgrounds meant that all the different people had different things that they could bring to the table. The staff were talented people from different professions who were interested in young people and wanted to give them different opportunities. The conditions of service were good, so the project was able to attract the best people around. Those that worked there had small caseloads and the calibre of the management and leadership was good.

660. Alongside the practice work, there was research and evaluation being undertaken. Prof David Smith, who was a professor of applied social studies at Lancaster University, carried out an evaluation of the project. He described the practice as "developmental and progressive in a context of voluntarism and interagency commitment to the welfare principles." The evaluation found that the project's outcomes were better than institutional programmes. I don't know what 'institutional programmes' specifically meant but I suspect it would be whatever programmes were in place at HMP&YOI Polmont, or even secure units, at that time.

661. The strapline for the report was 'Everybody Can be Somebody.' At the heart of the project was 'voluntarism'. The teams wanted to achieve with young people what I had wanted to achieve when I was at Dock Street. Although they were youngsters who had committed serious offences, the staff didn't want them feeling as if they were compelled to be part of the project. The teams wanted to make the young people feel that they wanted them there and they wanted them to be part of it. That was an important element of the success of the project. The project was very well designed, resourced, properly managed and encouraged quite strong family involvement. It had a good reputation and was a place that people wanted to work. This type of innovative

work was very unusual at that time in Scotland. Its results were very impressive. It was a place which was difficult to get young people referred to because everybody wanted their problem kids to go there on account of it being useful.

662. I think that the project became diluted following local authority reorganisation. Central Regional Council was split up into Falkirk Council, Stirling Council and Clackmannanshire Council. That resulted in the benefits of scale and the way it had been set up dissipating. There wasn't the same cohesion. A small council like Clackmannanshire Council found it difficult to resource. In the end, the project fragmented and didn't develop in the way it could have done.

663. Another positive scheme that I was indirectly involved with surrounded six or seven units that were set up in England and Wales. I don't think there was a name or term that was applied to the units. Up until 2013 there was several relatively small, well-resourced facilities for seventeen-year-old female offenders within the grounds of women's prisons in England and Wales. The prisoners were individuals who had been convicted of very serious offences, offences much more serious than those committed by the young people involved with the Freagarrach Project. The buildings were designed to a Category B specification and it was high security. The young women they were working with were sometimes difficult. They were women who had committed horrific offences and quite often were capable of harming themselves at the same time. They would stay within the units for a year before being absorbed into the adult female prison population.

664. The units were like small very well-run prisons within prisons. The small scale allowed key worker principles to be followed better than anywhere else I had seen. They had higher staffing levels than other prison settings and they had lots of specialist staff on site. There were dedicated teachers, psychologists and nurses. The facilities were better funded, and they had good meals. They were handpicked staff who wanted to work with young people.

665. HMIP inspected the units over about a five-year period. We saw them develop into really good units. We graded the units on four areas, 'safety', 'respect', 'activity' and

'resettlement'. Towards the end of the period, we were giving those units top marks across all the four areas. At that time that was very unusual. There were very few other places that achieved that. The ingredients that I think made them work so well were that the people in charge were committed good people who understood kids and weren't judgemental or punitive towards them. The units had well developed child protection procedures and they were open establishments when it came to transparency. They welcomed inspectors and wanted to know if anything was found out to be wrong so they could sort it out. The staff were able to get a good balance of care and control. They were professional and on top of things like bullying, drugs and self-harm but, at the same time, they were very caring in their approach. They had sufficient time to gain trust and build up good relationships with the young people in their care. Putting everything together they were quite impressive places.

666. HMIP had very limited insight into how successful the units were at rehabilitation, nor how successful they were when the young women were moved into the adult female prisoner population. Unlike the Freagarrach Project, there wasn't that evaluation ongoing. I never saw any research attached to exploring the outcomes for the young women who were in the small female units. However, we did see the work that was going on and felt it was a good start. Ultimately, it was realised that the units were quite expensive to run. I think it was their expense that ultimately led to them being closed. I think it was purely a financial thing that led to them being all closed by 2013. Looking back, you could see that they were doing something good in the units. They really were impressive. It's sad to think that all that good work could be forgotten. It was a good model that worked.

667. Around 2014, Kate Donegan, who was the governor at HMP Polmont about ten years ago and had previously been my boss at HMP Cornton Vale, contacted me. She had been encouraged to contact me for advice regarding where there had been good practice for under-eighteen-year-old boys in custody. At that time, they were considering building another wing at HMP Polmont because the numbers were going up. I emailed her back saying that there was no good practice, and it was a bad idea to build a new wing. I said to Kate Donegan that if they built another wing, they would just fill it and the same problems would continue. I told her that they should be thinking

about community alternatives like the Freagarrach Project and that should be the way forward.

668. I don't think I mentioned to Kate Donegan the small units that I saw in England and Wales that I felt were working. They were great places when comparing them to the other establishments where young people might end up. However, I think it is more important to make things better when young people are younger so they don't end up in custody at a later age. Building more space to house them isn't the answer. The Freagarrach Project can demonstrate, through Prof David Smith's evaluation, better outcomes for young people who have the potential to remain within the prison system.

The lack of campaigning culture and academic research surrounding secure care, prisons and penal reform in Scotland

669. One of the biggest differences I can see between Scotland, England and Wales when it comes to secure care and the prison system is an absence of what I would call, 'a campaigning culture.' I would say that Scotland overall is at least ten to fifteen years behind England when it comes to that. I can only think of a few examples where that culture has existed and exists within Scotland.

670. There was some interesting work that the Church of Scotland did into the immigration service provided at Dungavel House Immigration Removal Centre. The Church of Scotland campaigned to support children and families who they felt were being placed there unfairly. That campaign generated some groundswell in the community and involved schools and other organisations.

671. The Howard League for Penal Reform have a presence in Scotland, but they are not nearly as prominent as they are in England. In England they have eminent people in charge who speak out when something happens where there is a perceived injustice. Those views are often noted in the mainstream press.

672. The Prison Reform Trust also has very limited presence in Scotland. I think they have a representative in Scotland, but they have no real voice. Inquest is another

organisation that campaigns effectively in England. They are led by Deborah Coles who is a very well known, confident and articulate figure. She is very vocal when there is anything notable concerning deaths in custody, safety issues and things like that. She is a 'go to' person for the press and television.

673. Beyond the Dungavel campaign and the limited impact of The Howard League for Penal Reform and The Prison Reform Trust, there has been a notable absence in Scotland of the sort of campaigning activity that would exist in England. There has been no real voice in Scotland in that respect. There is no equivalent 'go to' person in Scotland.

674. I think Linda and Stuart Allan are beginning to emerge in that role. Linda Allan is a senior nurse and associate professor at one of the universities. She comes from a strong research background. Her husband is an analyst with a private company. Together they're quite a formidable duo. The Allan's daughter committed suicide in HMP Polmont five years ago. Their daughter was a student who was serving a custodial sentence after being found guilty of drink driving. The Allans feel that the conditions in HMP Polmont were poor and that their daughter had been bullied by staff and that this contributed to her death. Both Linda and her husband have been campaigning generally about the conditions young prisoners are kept in within HMP Polmont.

675. I introduced myself to Linda Allan and had a brief conversation. That led to me being invited round to their house. We discussed their campaigning, and they informed me that they had gone back many years and undertaken a really in-depth analysis into FAI findings. I think some of the preliminary work for their daughter's FAI is going to start in July 2022, but I think the hearing starts more fully in January 2023.

676. I learnt from the Allan's that there are two separate FAIs being held together concerning deaths in custody, one of which involves a young man who was sixteen. I believe that it is quite unusual to link two FAIs together and is being done to identify trends and links between the deaths. I believe because both the deaths occurred within the space of a relatively short period of time. I think there is the hope that

through combining the two cases together they will be able to take a more strategic overview rather than dealing with each case as a snapshot without really following through.

677. Academics are relatively quiet in Scotland on the subject of the condition of penal establishments and secure care. From my own knowledge there are only a couple of organisations that come to mind. The Children and Young People's Centre for Justice (CYCJ) do some good work, but it is theoretical and rarely gets publicised outside the academic community. It might have an impact on policy, but it doesn't seem to be having much of an impact on practice.

678. Professor Sarah Armstrong and her work with The Scottish Centre for Crime and Justice Research (SCCJR) is the only other academic project I am aware of. They are working quite closely with Linda and Stuart Allan. They have been a bit more vocal and involved with campaigning. They have published a couple of high-quality reports exploring things like how many recommendations are implemented further to FAIs, what actions Sheriff's take and so on. 'Nothing to See Here? 15 years of FAI determinations for deaths in custody' dated 5 October 2021 is the name of the original report and 'Still Nothing to see here? One year update on prison deaths and FAI outcomes in Scotland' dated November 2022 are the reports attached to the research.

679. In the most recent research undertaken by SCCJR, they found that there had been a higher number of deaths in Scotland between 2020 and 2022 than in any other three-year period preceding it. They found that family involvement in the FAI process remains low. That had been a previous criticism that SCCJR had made that hadn't changed very much. One of the more important things that they found was that Sheriffs identified even fewer precautions, system defects and recommendations than they found in their earlier reports.

680. SCCJR analysis is clear that progress is not being made and nobody is making the effort to monitor or investigate whether recommendations are being implemented. What SCCJR want to do is change that and to make the FAI process a system which involves families more and takes effective action to remedy defects and things that

have been identified as weaknesses in the past. The research appeared to me to be very good and produced some interesting findings.

681. I think the absence of a campaigning culture in Scotland has had an impact on the level of scrutiny of establishments in Scotland. That is a contrast with England and Wales where campaigners have managed to influence real change. I think that probably the same range of attitudes exist in Scotland as do elsewhere. In terms of making the change so that campaigners have more of a voice, space needs to be found for people like Linda and Stuart Allan with appropriate resources provided.

682. If the criminal justice framework in Scotland could find a place for people like Linda and Stuart Allan that would definitely provide more of an independent and distinctive voice. They are highly credible, competent, professional people who provide something additional that currently does not exist in Scotland at the moment. At the moment, it strikes me that the regulatory and justice framework in Scotland is rather insular, inward looking and lacks sufficient independent scrutiny. There is no grit in the machine. People are all connected and they all work together. Maybe that is inevitable in such a small country.

The character of staff members who are either alleged or convicted abusers

683. I think it is important to look out for the dangers of charismatic leadership. That characteristic can be very positive if you have the right person in the right role. I saw GHK in his role at the Kibble in the seventies and eighties operating positively. Douglas Davies in his role in nineties at Ballikinrain is another example. They were both charismatic leaders who had good values. They were decent sound people who had the best interests of the children at heart. They used all the power in they had access to so that they could exercise things in a constructive positive way.

684. In the wrong hands, that profile can be disastrous. Frank Beck, who worked in childcare for Leicestershire County Council in the seventies, comes to mind. He was charismatic and impermeable which is a bad combination. He impressed colleagues with his prowess with dealing with vulnerable young people with behavioural and

emotional problems. However, at the same time he was abusing the children in his care. He manipulated his staff and the whole system. He operated under a cloak of secrecy with few checks and balances and no effective scrutiny. The senior manager who employed Frank Beck employed him because he kept a lid on things and sorted problems out. When Frank Beck was convicted for abuse, the judge said, "you are a man of considerable talents and very great evil." I think that judgement sums things up. That is the danger when you allow the wrong sort of charismatic person to have power.

685. [redacted]

686. [redacted] Frank Beck are examples of people who were able to seduce and condition both children and the systems they worked within. They bullied, hypnotised and conditioned the staff and people around them to do what they wanted them to do with the children. They made sure that things were difficult to be found out about. They worked their magic in the background and made sure that the children and staff didn't speak. It is as if they had 'personality plus'. They had personality and charisma but, at the same time, had that evil within them to hold things together. I think that was what made them difficult to work out. They were so good at manipulating people around them that they managed to get away with things.

687. Looking back on my own experiences, and the situation with [redacted] at Lingfield Hospital School, everybody could see that, at the very least, he was showing favouritism towards an individual child. That should have been challenged and questioned. I think that he was able to do the things I suspect he did because he had elements of that charismatic personality. He was popular and people liked him.

People wouldn't want to question his practice, raise any issues or challenge him. The organisation failed to tackle that. Had there been a healthier more open culture about standards and what was right or wrong, it would have provided more confidence to the relatively more junior members of staff to be able to safely express views. That would have allowed for more constructive conversations to take place and there would have possibly been an opportunity to think about checks and balances. Unfortunately, none of those things were in place at that time.

688. The lesson to be learned is that you just need to be careful all the time. Things should be continually questioned, and assumptions shouldn't be made. Anything can be possible, and you can't be 100% sure about anyone or anything. You must believe what the children are telling you. I don't think those responsibilities need to lie with one individual or organisation. Those responsibilities need to lie with everybody whether they be the cook, the administrator or the chief executive. In the best places I have worked, there has been credence and credibility given to junior people as well as senior people. It must be everybody because individuals can't do it on their own. Different people will have different pieces of the jigsaw. Everybody needs to be encouraged to question.

Cinderella services in residential care

689. Residential childcare remains a Cinderella service. The phrase Cinderella service isn't a controversial phrase to use. It is an established phrase used in the sector both by those working directly in residential care and those working in fieldwork. A Cinderella service is where care is provided by unqualified staff as opposed to qualified staff with experience in providing fieldwork services. Generally, staff members involved in that sort of service aren't given a fair crack of the whip in terms of accountability, responsibility and generally being able to do what is needed. They don't have agency when it comes to decision making for the child in their care.

690. Secondary Institutions - to be published later

691. Secondary Institutions - to be published later

Gatekeeping

692. Gatekeeping is important in any children's home, whether they be local authority or independently run. Decisions about what the function of the unit is, who the residents are at any one time, who leaves and who arrives historically have been taken at a middle to senior management level with input from the manager of the establishment. In my experience, it is essential that the person running the establishment has a veto on who arrives and departs. Secondary Institutions - to be published later

Secondary Institutions - to be published later

693. How can you possibly parachute in emergency placements at the last minute and expect that not to be disruptive? Nobody's needs are going to be well met in a situation like that. I've seen first-hand where decisions are made by persons outside the establishment, and it has resulted in things being bad for the children already present, bad for the staff and bad for the child who is parachuted in. Nobody comes out of that situation as a winner.

694. The people running the establishments need to have a say in who comes in. That simple change would make a massive difference. I appreciate that would require colleagues elsewhere swallowing a bit of their pride, being a bit more understanding and tolerant and being a bit more patient about the child they are advocating on behalf of. However, at the same time it would allow the wellbeing of the existing children in the unit to be prioritised.

Proclamations of establishments

695. When I think back to my time working in the Kibble, there was quite a lot of talk about different establishments. Part of the culture back then was that every establishment would tend to think that they had the most difficult children and that they were the best. There was talk about places that were 'too soft' and places that were 'too tough'. That has continued in a different way to the present day. I think that establishments need to be a lot more careful about what they promise they can deliver. It has irritated me over the years when I have seen statements from local authority and private providers claiming that they are 'centres for excellence.' I've seen all sorts of immodest, outlandish, unrealistic standards being set by those sorts of organisations. In my experience, in practice, those establishments are very seldom meeting their own statements.

696. Highly elevated statements from establishments about being 'centres for excellence' and so on doesn't work if, at the same time, you are paying your staff abysmally. Either pay the right wages or don't wrap up what is happening in dishonest sentiments. Establishments need to be honest about things. I wouldn't even consider the well-run establishments and projects, such as the small women prison units in England and the

Freagarrach Project, in that light. They are a long way down the line but, in my view, there aren't any centres for excellence. There is something very unhealthy about local authorities pretending services provide superb top-class care for kids when it is not true. We really need to stop establishments boasting about being 'centres of excellence'. It is such an insulting way of approaching the work.

Transparency

697. Early in my career I read that researchers were concerned where there was a "lack of permeability". They meant that where it was not possible to shine a light through an institution, this could be dangerous. What you don't want alongside a lack of transparency are charismatic leaders who are dodgy. When you have those two things together you end up with situations like the Pindown crisis. That's when you get those big, terrible things institutionally going wrong. Staff members get away with things because they are skilful and charming with the kids and staff, both junior and senior. That is when you have senior members of staff saying things like "oh just let him get on with it, he sorts it because he knows what he is doing."

698. In my experience, wherever inspected bodies try and avoid or protest about being inspected this is concerning. When situations occur like that it should automatically ring bells and questions should be raised. Establishments need to be open and not impermeable. The places that society continues to fund to look after children have to be run in such a way that they're happy about being scrutinised. Organisations need to be happy with lights being shone on them. They should be demanding scrutiny and wanting questions to be asked.

Care and control

699. There has always been a challenge when it comes to balancing 'care' with 'control' in residential care, secure care and the prison system. It is something that is difficult to do and something the public doesn't understand. There is always the danger of over or under reacting and residential social workers often do not operate in an environment that is sympathetic.

700. The setting you are in is important when considering the level of control an establishment has. Sometimes, the staff in secure care and prisons are professionally trained and know about all the physical security side of things. They can administer restraint in a professional manner. Places like some of the smaller units I was inspecting in women's prisons in England, were able to do that whilst showing their caring side as well. That's one of the few examples where I saw that balance of care and control working effectively. Ordinarily, places that provide secure care can provide therapeutic care but are unable to provide effective control when things are kicking off. The staff would be backing off if there is a young person smashing a pool cue across a table. There are just some people who can't tolerate bad behaviour and their immediate instinct is to punish children. That's no use because it is the trauma informed approach that we want. In recent times the trauma informed approach has moved beyond relying on staff common sense. I think now it is really starting to show what a benefit it is.

701. It would take a cleverer person than me to explain all the ins and outs of balancing child safety with children's rights for children in care. It is just constantly difficult for staff to get the balance right between care and control. What you do need are the things that Angus Skinner and Eddie Frizzell were talking about in their reports. You need to recruit the right people and the manager needs to be able to set the tone. You need people who have both the professional skills and human qualities required. The staff need to be mature, resilient and interested in children. It can be difficult to find the people who have that repertoire.

The children's hearing system

702. Historically, there was a perception that the children's hearing system in Scotland was a much more advanced and pioneering system than the way the English system worked. It had a reputation for being very progressive and advanced. The children's hearing system, if there was a good panel representing the needs of the child and the child was represented and could have their say, was a great forum to thrash out difficult

problems. They were perceived to be good forums for forming compromises and listening to different points of view when attempting to sort things out.

703. In my experience, in some instances, there was a sense that the child's best interests were paramount. We wanted to give them the chance to speak. We wanted to hear what they would like, and we wanted to see whether we could build upon that. Reasonable steps were taken to make sure that the child had the opportunity to say what they thought. Realistically, there were limits to what could be done. Most of the children, if they spoke, would say that they wanted to go home. That decision could only be made if it was safe to do so. There had to be evidence to show that sending the child home was appropriate.

704. My own experience of the children's hearing system is mostly historical, however, I have heard, following conversations with colleagues who are currently working in residential childcare, that the children's hearing system has become more legalistic and less effective. Seemingly, it is now more like a formal court procedure where instructions are given, people don't listen to each other, there is not much common ground established and, at the end of it, there is little common resolution. To my surprise, I have heard that social workers are being boxed into a corner a bit. I've heard it is quite often dominated by advocates who are often legal representatives acting on behalf of disaffected parents who want their interests argued prominently. Sometimes those interests can be against the best interests of the child. That complete shift in dynamic wasn't one that was happening when I was involved with children's hearings. It is no longer a welfare-based forum where the child's best interests are front and centre.

705. What is described to me now sounds more like the youth courts system in England. The youth courts system is more adversarial and legalistic. It could be that the time I engaged with the children's hearing system was the 'golden age' when it was working as it was intended to be. It sounds to me as if it has changed quite a bit. I don't know why that had happened, but it could be something as crude as the availability of legal aid for hearings.

Vetting and recruitment

706. Recruiting the right people is easier said than done and I've admittedly made mistakes in my time. Vetting is difficult, cumbersome and time consuming. However, there is no escaping that it is something that is essential. I am aware that there is now SSSC registration and a PVG system in place that requires people to refresh their disclosure certificates every three years and when they start new jobs. I'm also aware that there is an enhanced clearance required for those people who work within prisons with more detailed checks undertaken. That is probably a better process than was in place when I started my career.

707. When vetting and recruiting a person nowadays a balance is attempted to be sought against protecting people's civil rights and data protection. I do think that we still need to make best use of informal information. The thrust towards equal opportunities and more scientific approaches in recruitment has resulted in some of the good bits of the old systems being lost. You want people who present well but I don't think that is sufficient on its own. I think there is a danger with the competency-based approach that you find yourself in situations where candidates have schooled themselves to respond to it.

708. I think that having a good sound experienced person chairing the panel with two switched on experienced curious people, who are a bit nosey, allows good conversations with candidates to be elicited. When it comes to candidates, you need to be looking for people who are likeable and interesting. You need to be looking for someone who is interested in you and other people, has a sense of humour and is evidently good at what they do. The candidate needs to be confident and have the simple ability to talk to people. You can be loud or quiet, but you need to be a good communicator. Having a panel as I describe and looking for those qualities in candidates allows you to come to a balanced judgement. It allows you to balance objective information against subjective information such as the candidate's warmth, how they come across as a person and their presentation of themselves. I appreciate that it is very difficult to quantify those qualities using modern fair methods, however, I do think there is a value in that.

709. The best predictor of future performance is past performance. I think that that needs to go beyond just taking references and following them up. In the old days, as well as interviewing the candidate, you would call up someone who knew the candidate. I knew quite a lot but there were people who knew ten times more than me and would have access to information that I just wouldn't know. You would speak to somebody, sometimes slightly off the record, who worked with the candidate at a previous establishment. You wouldn't need much and would be only looking for things that were good or bad. Anything in the middle would be countered by what you would get in the interview. The informal information received might not be a dealbreaker in terms of your decision making but, at the very least, it might trigger further investigations and enquiries. I think that informal approach was beneficial when recruiting staff. If we could still somehow make use of that informal system alongside the formal fair system it could only be a good thing. I don't know how you could do that without breaching someone's rights, but it is something that needs to be considered.

710. User involvement historically used to be a lot more prominent in recruitment processes. That was certainly the case in the eighties and nineties. Sometimes it was a bit tokenistic but, nonetheless, it was a useful strand. In my experience, it was always good to involve the children staying at the establishment in the recruitment process of new staff. It allowed you to gain instinctive feedback about candidates. I remember comments like "I have a bad feeling about that guy" from users and finding them useful. They weren't comments which could be ignored and would trigger us to undertake further checks just to make sure there was nothing wrong present. You wouldn't use the comments from the children solely as a reason for whether to appoint someone, but you could use that information to investigate things a bit further. I think that is a legitimate approach.

711. One further suggestion might be to be a bit more rigorous with probation periods. There could be an argument that they need to be longer and more vigorously applied for those people who work with children.

712. I remember the chief inspector at HMIP, Nick Hardwick, following a particular inspection, underlining that inspectors needed to be vigorous and constantly question everything all the time. Assumptions about people you are recruiting should never be made because you just can't be sure. Things shouldn't be taken at face value when you are recruiting and vetting staff.

Appropriate renumeration and conditions for staff working in residential care

713. There is something about prestige and status that helps attract the right people into the profession. On the continent they pay their best people good money to carry out these kinds of jobs. It's a highly skilled, trained, rewarded and regarded role. It is seen as an attractive career to pursue. Unfortunately, that sense of prestige does not apply in the UK. We are good at doing that with certain professions that work with children in this country, like paediatricians, but we don't do that with people who work with children in other roles. Why shouldn't we have that same level of regard for social workers and care workers?

714. When I look at advertisements for roles working in residential care, and look at simple things like salary ranges, they are way behind other professions. The best places I have seen are small places where, although they aren't getting the economies of scale, they are getting the right people in. [redacted] However, we could only take things so far. It's an old cliché but good practice is expensive. It's not something that you can do on the cheap. The work isn't 'rocket science' but you need to be rewarding the people who are employed in those roles appropriately.

715. Something as crude and basic as not providing a decent salary to staff is a basic example of the level of regard we attribute to those working in residential childcare. In my experience, if you try to run residential childcare on the cheap you end up with people who are not interested in the work and are less resilient. That only ends up with those staff members going off sick. You then need to hire a replacement under the same conditions of service. I've seen examples where that replacement then goes off sick. You can end up paying three times for the one post. If, instead, you employed

a high-quality person and paid them fairly for the difficult job they are doing, you can run a really good resource.

716. I experienced a period where there was a burst of positivity in the early to mid-nineties from Central Regional Council and there were real efforts made to upgrade the staffing in residential childcare. They invested good money so that they could attract good people and improve practice. That is exactly what happened because of that investment. For a period, there was clear evidence that that approach made sense. The Freagarrach Project is another example of an organisation that was well resourced and paid its staff fairly. They too benefitted from that in terms of the quality of the staff they recruited.

717. If you pay a fair wage you are going to broaden the pool of staff available to be recruited. Paying staff fairly is just one of the ingredients needed to get the quality of staff in that you need, however, it is an important one. You don't want people who are solely motivated by money, however, money is important. The higher level of renumeration was what attracted me back to Central Regional Council to take up my role at Dock Street.

Qualifications, training and career development

718. I think that training and qualifications are necessary, but they aren't sufficient on their own. What's more important are the personal attributes of the individual. You can get someone who is well trained and experienced, but not particularly effective. I saw evidence of that at the Kibble and other establishments over the course of my career. Ideally, what you would be looking for is somebody who has those attributes alongside their qualifications. In my experience, that is where recruitment works well in the residential childcare environment.

719. In the past there were senior certificated courses for those who worked, or wanted to work, in residential care. I remember those being offered in the North of England. However, I'm not sure whether those courses are still available or have the prestige and status that would attract the right type of people who would want to complete them

now. Nowadays, I just don't know where there is an attractive, good quality residential childcare course that is designed for somebody who wants to enter that field and have a good career in it. I think that someone who is genuinely interested in that work would probably have to do a generic social work training course. I don't know what they could do beyond that when it comes to certified training.

720. Career development needs to be a possibility for those who want to progress in residential childcare. When I started out in my career in residential childcare, I knew that I couldn't remain in a field that was highly stressful, relatively low paid and didn't provide great prospects. Through providing better prospects and career development opportunities, you have the chance of keeping the good people you employ.

Unconditional regard and love

721. There are all sorts of boundaries and rules in place that we, as workers, need to follow. Those boundaries and rules inevitably influence how we can provide care to the children in our care. During our training in Milwaukee in 1995 I attended a talk about work and research associated with Carl Rogers. Carl Roger's ideas surrounding the therapeutic approach when developing relationships permeated the whole conference. The ideas were very current and influential at that time.

722. I don't specifically remember who the speaker was, but he was a retired professor of social work and was a brilliant communicator. There were lots and lots of presentations. I remember academic speakers at the conference including Leon Fulcher and Frank Ainsworth. Whoever provided the talk said that what people needed to develop with children in care was a relationship where the social worker thinks the child is fantastic regardless of their behaviour. He described that set of circumstances as 'unconditional regard.' The social worker needed to maintain telling the young person that they were great no matter how many things they had been involved in. He said that was what children in care did not have access to. The speaker's comments regarding unconditional regard, and other things, really chimed with me. It made a lot of sense to me when reflecting on my practices.

723. Unconditional regard is something that can be provided in a family setting but is difficult to maintain in a care setting because of the rules and boundaries staff must work within. I don't know how you can overcome the gap between the unconditional regard provided in a family setting and what is present for the child in a residential care setting. I think unconditional regard needs to be separated out from love. Part of the Scottish Government's pledge for how children can be looked after safely is that they need to be loved. How can anybody outwith the family show love to a child that they are being paid to look after? I just don't think they can. I don't think that a paid carer can replace any parent. At the end of the day, carers are being paid to undertake a transaction at a basic level. Because of that the relationship will just never be quite the same.

724. Anybody who has worked in the field will tell you that the child will always pick returning to the family home over being cared for by people who are paid to look after them. I think that's just human nature. The best a carer can do is to be honest and show integrity in their relationships whilst being respectful and carefully showing a bit of affection. I'm uncomfortable about the love thing. I don't think a carer can show that unless it is a very young child who has been fostered or adopted. Sadly, the relationship is never going to be as good as what would be present in a loving family. Carers can only do the best they can.

Involving care leavers and former prisoners in the inspection process

725. I think that it is important, when inspecting establishments, to not only survey those who are currently in care within the establishment but also those who have recently left the establishment. I think that surveying and involving young people, who have left care or prison, during inspections could act as a double test. I remember that during one inspection in England we made assumptions but found that the children in the establishment had completely different views through their responses in their surveys. It can be very difficult for children in care to speak openly and honestly when they are within the establishment or foster placement they are placed. I think children in care should be given the opportunity to comment on the care they received after leaving the establishment they were placed. I'm not sure what organisation could

undertake that work, but I imagine it would be an inspectorate such as The Care Inspectorate.

726. I know that they are testing out surveys with prisoners at HMP Polmont. I will be interested to see what the return rate is and what the response is that those inspecting that establishment receive. I think it would be interesting to compare whatever responses are received from young people in custody against a sample of responses from young people who had already left HMP Polmont. I do wonder whether the responses would be different from those who are safely sitting in their home six months or more after leaving HMP Polmont. I'm not sure how the surveying would be done on those young people who had left a particular establishment. I don't know whether that could perhaps be done by phone.

727. Another thing that might work would be to directly involve care leavers in the inspection process. I know that when I was at HMIP we had reformed criminals who had spent time in prison and sorted themselves out, who had an interest in that area of work, to come onto the teams and be part of the inspection process. The idea was to hopefully allow users to obtain a stronger voice in response to inspections. We gave that a good go but ultimately it didn't work because governors were nervous about security when letting those sorts of individuals into their establishments.

728. HMIP's attempts to involve reformed prisoners in their inspections didn't ultimately work out but I can't see why it wouldn't be a good idea to involve children who had formally been involved in care being involved in inspectorates. There could be a designated post as part of inspection teams for care leavers with their points of views and inputs being considered. Through having people on teams who are care leavers you would be able to elicit information that other people wouldn't be able to get. It would then be over to the inspection team leader to judge how much weight would be given to that. I think that would be useful as part of a wholly independent inspection team or organisation. It might be something to think about and a way of getting the user's voice more prominent during inspections.

Staffing levels and cover

729. Staffing levels and cover within an organisation are important. The more I think about the organisations that have worked, the more I see that is the case. The staff attached to the Freagarrach Project had small caseloads and weren't being bombed out. The young women units in England and Wales I reference earlier were all small scale. None of them held more than thirty prisoners. Most of them had as little as twelve or thirteen. The staffing levels were far better than standard prison run wings.

730. Both those examples didn't have extravagant staffing levels but had sufficient levels to allow people time to establish relationships with the young people and to operate the basics of a key worker scheme. In the units, because morale was good and they were well led, there was low sickness and a continuity in terms of the care provided. Admittedly, the expense required was more than a standard wing in a normal prison. However, I suspect if evaluation was undertaken into outcomes for individual young people, they would be a lot more positive than on the normal wings.

Support for managers of residential establishments

731. It is important that you have senior management support. Secondary Institutions - to be published later Secondary Institutions - to be published later It isn't the sort of role you can do on your own. You hear people in the profession say, "You don't know what it is like unless you have worked in a children's home." I think there is some truth in that. I found that a lot of my colleagues who were fieldwork social workers just didn't understand what it was like working in residential childcare. I think it is important that people who are in more senior positions above multiple residential establishments have that experience.

732. Secondary Institutions - to be published later

Engagement with local community and society

733. Attempts need to be made to engage with the local community. That is perhaps more a role for senior managers. There was a need for that engagement when I was working in residential childcare and there will certainly still be a need for it now. There needs to be a constructive strategic debate about how to care for children in the community. Children in residential care come from the community. They are everybody's children and are part of a family.

734. In a healthy, civilised and modern society we should all be feeling some sort of obligation to help children who have lost their way rather than blaming and judging them. Unfortunately, that debate never really flourishes because the society we live within Scotland is critical and judgemental about children in care. In Scotland, we hide our children's homes in obscure places and make sure that they don't show any sign of being children's homes. We expect to get a bad reaction from local communities based on previous experience. Questions such as "Why are these children being allowed to go on holiday abroad when they have behaved so appallingly" are frequently raised.

735. I don't know why a positive, constructive debate doesn't occur in Scotland about children in care. It is something that seems to flourish elsewhere in places like the Scandinavian countries. In other countries there is the willingness to have more of a balanced healthy conversation about what should be done and how things could be better.

Mandatory reporting and the culture within the UK

736. You would think that you wouldn't need someone telling you that if something bad happens to a child it needs to be reported. That surely should be an instinctive part of being a mature adult in our society. I am surprised that we are still having arguments,

particularly with religious organisations and individuals, about when you should and should not report disclosures. I don't agree that there is any obligation to anything else that would trump not reporting something. I would be interested to know what happens with regards to reporting in countries that are cited as more liberal and progressive. Finland is often cited as a country that treats children in public care well with low levels of bad things happening to them. It would be interesting to see how they approach reporting within their society.

737. No matter how good an establishment is, or the community where it sits, bad things are always going to happen from time to time. Terms such as 'guilt', 'shame' and 'blame' fly about when child protection is discussed. That seems to be particular to the UK. It does seem that the popular press tends to feed off all that type of stuff a lot. I do think that they do some things better in some of the Scandinavian and European countries. It does seem that they are more able to take risks, gather support and operate in a way that is much freer of those negative terms when investigating and reporting where things have gone wrong.

738. I think it is partly the culture that we have in the UK that inhibits people wanting to report things. We need to extract the emotional response and just do the right thing. We need to try and understand things a bit more rather than rushing to a judgement and blame exercise. It's a shame that we have to formalise reporting and name it 'mandatory reporting'. It's sad that we, as a society, should need to teach people to do the right thing because it should be instinctive.

Final thoughts

739. I was conscious when I applied to the Inquiry that I didn't have anything hard-hitting and that I haven't directly observed any abuse. I'm disappointed, but sadly not surprised, at all the horrendous things that have come out in the evidence. When I read some of the things that applicants have said in their statements, I find it terrible. I am horrified by some of the things that I have read. I think any reasonable person would feel that way.

740. I recognise that I was working with children in residential care at the time of some of the disclosures that have already been made to the Inquiry. During the early stages of my career, I was inexperienced and wasn't trained. I didn't really understand the dynamics of the complex organisations I was working within. I think that may well be why I didn't pick up on things at that time. There are times when I think, with the benefit of hindsight, that there were things that weren't quite right. However, at the same time as those terrible things were happening there were good things going on in residential care. That was especially so with the List D system. There were a lot of talented people who subsequently rose high in the profession who started off in those establishments.

741. Both Angus Skinner and Eddie Frizzell in their reports showed, in their own ways, an understanding for how difficult the task of looking after children in residential and secure care is. They were very quick to condemn the bad things that happened but, at the same time, weren't saying that 'the baby should be thrown out with the bath water' and that all homes should be closed. They looked at what made residential childcare work well.

742. Eddie Frizzell describes in his report concerning abuse at Kerelaw the impact that residential childcare has on everybody. I find instructive two quotes. The first is where he says, "while those who were involved in abuse at Kerelaw deserve to be condemned and held to account, it should be recognised that there were also good practitioners at Kerelaw, and many young people valued the care that they provided." The second is in his summary with quite a modest but realistic conclusion where he

says "Kerelaw is closed now but there are still many young people who need residential care. If their needs are to be met, our social services require a trained and dedicated workforce which is valued by the public and their employers." I would totally agree with those comments. Residential childcare can be positive if you have the right people in the right roles.

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

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

Dated..... 24/8/23 .....