1 Tuesday, 12 December 2017
2 (10.00 am)
3 LADY SMITH: Good morning.
4 Mr MacAulay.
5 MR MacAULAY: Good morning, my Lady. The first witness this
6 morning is DCI Graham MacKellar.
7 LADY SMITH: Thank you.
8 Good morning. Would you take the oath, please.
9 DCI GRAHAM MACKELLAR (sworn)
10 Questions from MR MacAULAY
11 LADY SMITH: Do sit down and make yourself comfortable.
12 Mr MacAulay.
13 MR MacAULAY: My Lady. Good morning, detective inspector.
14 Are you DCI Graham MacKellar.
15 A. Yes, I am.
16 Q. How old are you?
17 A. I'm 52.
18 Q. How many years' police service do you have?
19 A. 28 years.
20 Q. And where are you currently based?
21 A. I am currently based at the Media Investigation Teams in
22 the west of Scotland.
23 Q. In 2015 were you attached to the Homicide Governance and
24 Review Body?
25 A. Yes, I was.

1 Q. What function did that particular body have to play?
2 A. A number of functions, primarily to review any
3 unresolved homicides, look at any new information, and
4 review them on a regular basis.
5 Q. Having been approached by the Inquiry in connection with
6 an investigation you carried out into the death of
7 Samuel Carr, did you provide with us a statement?
8 A. Yes, I did.
9 Q. If you look at the red folder in front of you, I think
10 you will find, amongst other documents in that folder,
11 the statement you provided; is that correct?
12 A. Yes.
13 Q. I will just give the reference for the transcript; it is
14 WIT.001.001.2804.
15 If you turn to the last page of the statement
16 detective inspector, at 2817 can we see that you signed
17 the statement?
18 A. Yes.
19 Q. You confirm that you believe the facts stated in the
20 statement are true?
21 A. That's right.
22 Q. Can I just look then to your involvement into the
23 investigation into the death of Samuel Carr. You tell
24 us in your statement that it was around April 2015 that
25 you were first contacted in that connection; is that

1 right?
2 A. I think it was April/May, around about that time; I'm
3 not sure of the exact date.
4 Q. What was the background then can you tell us?
5 A. We were contacted by the family protection unit in
6 Q Division --
7 LADY SMITH: Sorry DCI MacKellar, can you just wait one
8 moment; my documents screen has gone to sleep.
9 (Pause)
10 Yes, I'm there, thank you.
11 MR MacAULAY: You were going to tell us how you became
12 involved in this investigation.
13 A. Yes, I was contacted by a DC from Q Division. They were
14 investigating the death that had been reported to them
15 of a young boy called Samuel Carr. Their initial
16 enquiries had led them to believe that there may be some
17 unexplained circumstances surrounding his death and it
18 was felt that they should contact us as perhaps it was
19 more in our remit to continue with the investigations
20 into this death, rather than them continuing with that
21 inquiry. So I took that to my detective superintendent,
22 discussed it, and proposed that we should continue with
23 that side of their investigation.
24 Q. As you tell us in your statement at paragraph 3, did you
25 understand that Samuel Carr had died on 24 June 1964 at

1 the age of 6 years of age?
2 A. Yes.
3 Q. And your understanding was that he had been a resident
4 at Smyllum in Lanark?
5 A. Yes.
6 Q. I think you tell us that a number of officers worked on
7 this investigation; is that correct?
8 A. Yes.
9 Q. In the course of the investigation were former residents
10 from Smyllum interviewed?
11 A. Yes.
12 Q. Again, if you look at your statement at paragraph 6, do
13 you tell us, without naming the names, because we have
14 the redacted version on the screen, that statements were
15 taken from a number of former residents?
16 A. That's correct.
17 Q. In particular, if you look at paragraph 20 of your
18 statement, that's -- if you turn to page 2807 of the
19 statement, do you set out in paragraph 20 information
20 that you gleaned from, in particular, one person who
21 spoke to you?
22 A. Yes.
23 Q. Can you summarise what this was, what the information
24 was?
25 A. The information was that this former resident had been

1 with Samuel Carr. They were both around 6 years old at
2 the time and he recalled Samuel Carr showing him a match
3 and lighting a match and then giving this resident
4 a piece of material and lighting it with the match. The
5 material then ignited and it burnt the resident's hand,
6 causing him to scream, which alerted a nun, who
7 thereafter attended and, according to the resident, the
8 nun then started seriously assaulting Samuel Carr.
9 Q. In the course of the investigation did you seek to
10 recover and indeed recover a copy of the entry of
11 Samuel Carr's death in the Register of Deaths?
12 A. Yes.
13 Q. If you could look next please at INQ.001.001.2381. That
14 will come on the screen. In fact, there is a copy in
15 tab 2 of the red folder if you prefer to --
16 A. I'm struggling to read that without my glasses.
17 Q. We can work off the screen. That part of the entry in
18 the register that hasn't been redacted, can you see that
19 does relate to Samuel Carr?
20 A. Yes.
21 Q. We can see that the date of death is 12 June 1964 and
22 the age is age 6?
23 A. That's right.
24 Q. Then, if you look at the cause of death, can you see
25 that the principal cause of death is said to be

1 a cerebral hemorrhage?
2 A. That's correct.
3 Q. Would that be of interest to you in your investigation?
4 A. We would want to know what the cause of that cerebral
5 hemorrhage was, so yes.
6 Q. Can we see that in relation to box 7, in relation to who
7 informed the registrar of the death, that it was a child
8 care officer based at 73 John Street in Glasgow?
9 A. Yes, Mr Brownlie.
10 Q. Am I to understand that, having seen the death
11 certificate, you wanted to see whether there was
12 anything suspicious about the death of Samuel Carr?
13 A. Yes, we wanted to identify what the cause of death was
14 and that would lead us to understand whether or not it
15 was potentially suspicious or not.
16 Q. Were you appointed the senior investigating officer?
17 A. I was.
18 Q. So essentially although others worked with you, they
19 would answer to you, they would report to you?
20 A. Yes, that is correct.
21 Q. Was it important in your investigation to see whether or
22 not you could identify if there was a post-mortem report
23 on Samuel Carr?
24 A. That was pivotal to the investigation, yes.
25 Q. Did you make a number of efforts to see if you could

1 find a post-mortem report?
2 A. Yes, we did.
3 Q. I mean, you tell us, for example, in your statement that
4 you went to the Mitchell Library on one occasion; is
5 that right?
6 A. Yes.
7 Q. What was the purpose behind that?
8 A. We were led to believe that a number of medical records
9 from Yorkhill Hospital, where we believe Samuel was,
10 were held at the Mitchell Library. We did locate
11 records there but they related to 1960, I believe, and
12 not the year 1964 that we were interested in.
13 Q. Likewise, did you also make contact with
14 Yorkhill Hospital?
15 A. Yes, we did.
16 Q. What was the result of that?
17 A. Well, they told us that the retention period for
18 documentation, I think, was between 7 and 10 years and
19 also they had recently relocated and a lot of historical
20 documentation had been destroyed. Ultimately, they told
21 us they didn't have any documentation relating to
22 Samuel Carr.
23 Q. Apart from former residents who had been at Smyllum, did
24 you also contact and interview some of Samuel Carr's
25 surviving relatives?

1 A. Yes, we did.
2 Q. In the course of the investigation did you obtain some
3 information as to what Samuel Carr may have been doing
4 shortly prior to his death?
5 A. Yes, we did. [redacted]
6 [redacted] shortly before dinner one evening at
7 Smyllum [redacted] I believe -- observed
8 Samuel playing at the bin area, where it was forbidden
9 to play. So they approached Samuel and told him not to
10 play there, to come away before he got into trouble with
11 the staff or the nuns. They observed that Samuel was
12 using a stick and playing with a rat or rats.
13 Q. So that was something that featured at least as part of
14 the investigation and something you wanted to look at as
15 to whether that had any connection with his death?
16 A. There were several witnesses or former residents spoken
17 to who gave various accounts of their recollections as
18 to why Samuel died or what they were told as to the
19 reasons of Samuel's death. Several of them mentioned
20 that he had been poisoned by a rat or touched the blood
21 of a rat. There were various scenarios but several
22 accounts relating to him having contact with a rat.
23 Q. Another step that you took, I believe, as part of your
24 investigation was to obtain a search warrant to search
25 the premises of the Daughters of Charity in London; is

1 that right?
2 A. That's correct. Our enquiries led us to understand that
3 any documentation or paperwork relating to Smyllum at
4 that time and potentially Samuel Carr and the death of
5 Samuel Carr would be -- was held in London, so we
6 obtained a warrant to check those records and that
7 documentation.
8 Q. Did you yourself execute the warrant?
9 A. No, I didn't; two members of staff travelled to London.
10 Q. Were materials recovered under the strength of the
11 warrant?
12 A. Yes, there was.
13 Q. Was there anything recovered that helped you in relation
14 to the investigation into Samuel Carr?
15 A. No, not in relation to his death, no.
16 Q. I think one area of interest was to identify whether the
17 nun against whom the allegation was being made was still
18 alive; is that right?
19 A. That's correct. Our enquiries discovered that she died,
20 I think, in 2014.
21 Q. I think you tell us, if you turn to paragraph 45 of your
22 statement at page 2812/2813, that the nun involved,
23 Sister AGI, had died in Wishaw General Hospital on
24 [redacted] 2014.
25 A. That is correct.

1 Q. So that was a line of inquiry that was closed to you?
2 A. Yes.
3 Q. We have already touched upon statements that were taken
4 directly by your own officers. Did you also rely on
5 statements or statements taken at earlier dates in
6 connection with other investigations?
7 A. Well, what I had asked officers on the inquiry to do was
8 look at statements taken during previous investigations
9 surrounding Smyllum as two of the officers on my team
10 had been involved and had a knowledge of these
11 investigations. So I asked them to look at these
12 statements to see if there was any reference to
13 Sammy Carr and indeed Sammy Carr's death, just to see if
14 that could assist us in progressing the investigation.
15 Q. Can I take you to this statement please; it is
16 PSS.001.001.0391. The name of the person making the
17 statement has been redacted, but can we see that as far
18 as the date is concerned, it is dated 28 October 1999;
19 is that right?
20 A. That's right.
21 Q. So this was in connection with another inquiry not the
22 one that you were directly involved with?
23 A. That is correct.
24 Q. Can I take you to page 0400. If we look towards the
25 bottom part of the -- in fact, I think it has been

1 marked up -- can I just read this to you because this
2 was something that probably featured in your
3 investigation. This witness is saying:
4 "I recall a young boy called Sammy Carr who was very
5 small when he came to Smyllum. He had the bed next to
6 mine in Sacred Heart. As was [sic] only very small and
7 cried when he came in, he was beaten by staff (female)
8 and the nuns and by ████ because he cried a lot. When
9 he was beaten in the dormitory I would hide under my
10 blankets because I was so upset and afraid. I would
11 hold his hand whilst we lay in our beds --"
12 Moving on to the next page, 0401:
13 "-- to try and comfort him. Most boys stopped
14 crying [I think] after the first few days as we got used
15 to the place, but Sammy kept crying. He was there for 2
16 or 3 months and he cried for most of the time, and as
17 a result was beaten for most of this time."
18 That's information you had in connection with how he
19 was being treated at Smyllum?
20 A. Yes.
21 Q. In due course, in the course of this investigation, you
22 did in fact come across the post-mortem report.
23 A. Yes, we did.
24 Q. Was that a breakthrough?
25 A. Absolutely, yes.

1 Q. You tell us about that on page 2814 of your statement.
2 If you go back to your own statement at paragraph 50,
3 perhaps you can just help us as to how it came to be
4 that you came across the post-mortem report.
5 A. We had been searching for this post-mortem report, we
6 had approached several agencies, the usual place would
7 be to contact Marjorie Turner, a pathologist who
8 the Crown uses -- the Fiscal uses for post-mortems. But
9 she could not find this post-mortem report which had
10 gone to the Crown. All attempts to try and trace this
11 had been met with a negative result.
12 I met with Marjorie Turner and mentioned this to
13 her, that we were still involved in this investigation
14 and I was still frustrated as to not being able to trace
15 this post-mortem report, so Marjorie told me she would
16 make further enquiries and contacted me a few days later
17 and told me that she had in fact been able to locate the
18 post-mortem report with the paediatric pathologist at
19 the Queen Elizabeth University Hospital in Glasgow.
20 Q. Do you know why the report had been retained there?
21 A. When I met with Dr Penman and Dr French, they told us
22 that they retained all post-mortem reports for children
23 going back for, I think, 100 years. So the normal
24 retention period used by the hospitals perhaps in the
25 NHS wasn't used by them, so that was of great benefit to

1 us.
2 LADY SMITH: I think if I remember rightly, it is not just
3 a matter of retaining records, but if there are any, for
4 example, tissue slides from the post-mortem, they are
5 kept safely as well in that department --
6 A. They have kept theirs as well.
7 LADY SMITH: -- and indeed have on occasion been of great
8 assistance to the Crown investigating older cases.
9 A. Yes.
10 MR MacAULAY: I think in fact the slides were there.
11 A. Yes, we were shown slides when we met with the doctors.
12 Q. So if I take you then to the report, at
13 PSS.001.001.0306. The copy is a bit smudged --
14 A. That's it.
15 Q. That is it, isn't it?
16 A. Yes.
17 Q. Can we see that according to the information provided
18 that Samuel Carr was admitted to hospital on 2 June 1964
19 under Dr Shanks and that he died some ten days later on
20 12 June 1964?
21 A. Yes.
22 Q. Can we see that the post-mortem was carried out on
23 13 June 1964?
24 A. Yes.
25 Q. You wouldn't claim to be an expert in forensic medicine

1 or pathology, so I think you decided you needed some
2 assistance to see what this report actually said; is
3 that right?
4 A. Yes.
5 Q. Is that where I think you mentioned Dr Penman and
6 Dr French? You got in touch with those two doctors?
7 A. (Nods).
8 Q. Were they consultant paediatric and perinatal
9 pathologists in the Queen Elizabeth Hospital?
10 A. Yes, that's where they are based.
11 Q. I think eventually you got a report from them, but
12 before that did you have a meeting with them?
13 A. Yes, myself and the DS, Lyndsey Laird, attended at the
14 hospital and had a meeting with both doctors.
15 Q. What was the message at that time from both doctors in
16 relation to the cause of death of Samuel Carr?
17 A. In essence what they told us was that Samuel had died
18 due to an infection in his brain.
19 Q. Did they produce for you a report to back that up?
20 A. Yes.
21 Q. If we look at PSS.001.001.0262, is that their report
22 dated 14 June 2016?
23 A. It is, yes.
24 Q. Looking to the third paragraph, can we read that:
25 "It is the opinion of Dr French and myself that the

1 cause of death of this child has been cerebral abscesses
2 which are due to fungal infection, most likely, on the
3 basis of the morphology, an Aspergillus ..."
4 That's a form of fungus?
5 A. Yes.
6 Q. They do raise, I think in the second page, a question in
7 relation to neglect because they say:
8 "There is no evidence either on the macroscopic
9 report or in the histology, either now or previously, of
10 significant trauma (within the limits of the information
11 now available). However, neglect is one possibility in
12 a list of many potential causes for Samuel's
13 vulnerability to the cerebral Aspergillus infection
14 which, in our opinion, has been the cause of his death."
15 A. That's correct.
16 Q. But having had that advice from those pathologists,
17 where did that leave your investigation?
18 A. Where it left us was, according to the doctors, there
19 was no link in relation to the assault witnessed by the
20 former resident on Sammy Carr by the nun. Although they
21 had mentioned potentially neglect was one of a number of
22 reasons that Samuel's immune system would have been so
23 weak as to allow him to have caught this infection, we
24 couldn't evidence what had caused that as we had no
25 medical records for Samuel. So my assertion was at that

1 time we had identified the cause of death, we had
2 identified that there was no link, causal link, from the
3 assault, so I compiled a final briefing paper for my
4 line manager for onward transmission to the detective
5 chief superintendent to discuss whether they wished any
6 further inquiries to be carried out by ourselves in
7 relation to the death of Samuel Carr.
8 Q. Was the decision that there be no further inquiries?
9 A. Yes, that was correct.
10 Q. I think you did contact family members and other former
11 residents to let them know the outcome of your
12 investigation.
13 A. I instructed our family liaison officer, DS Laird, who
14 had conducted all contact with the family, to meet with
15 them and explain to them exactly what inquiries we had
16 carried out. She had kept in touch with them throughout
17 the inquiry, but to sit down with them and explain
18 exactly what we had done, how we had found -- located
19 the post-mortem report, how we had sat down with the two
20 doctors, the pathologists, had the post-mortem explained
21 to us, and thereafter we were able to explain to the
22 family exactly how and why Samuel had died.
23 We were also able to return photographs of Samuel to
24 the family at that time, which we had recovered. We
25 also asked the permission of the family as to whether

1 they were happy for us to inform and update the
2 reporter, ie the former resident who had initially
3 approached the police, as he had been in touch with is
4 several times regarding the progress of the
5 investigation. The family were happy for us to do that.
6 So we then contacted the reporter as such.
7 MR MacAULAY: Very well. Thank you, detective inspector.
8 I haven't received any written questions for the
9 detective inspector, my Lady, and I don't know if there
10 are to be any questions.
11 LADY SMITH: Let me just check. Are there any outstanding
12 applications for questions for this witness? No.
13 There are no further questions for you, detective
14 inspector. Thank you very much for coming along this
15 morning and helping us with your evidence to understand
16 the researches that you carried out on this case. I'm
17 able to let you go.
18 A. Thank you.
19 (The witness withdrew)
20 LADY SMITH: Yes, Mr MacAulay.
21 MR MacAULAY: Yes my Lady. The next witness I would like to
22 call is Professor Busuttil.
23 LADY SMITH: Good morning. Will you take the oath please.
24 PROFESSOR ANTHONY BUSUTTIL (sworn)
25 LADY SMITH: Do sit down and make yourself comfortable.

1 Mr MacAulay.

2 Questions from MR MacAULAY

3 MR MacAULAY: My Lady.

4 Good morning, professor.

5 A. Good morning.

6 Q. Are you Professor Anthony Busuttil?

7 A. I am.

8 Q. I'm going to put your CV on the screen in front of you.

9 You will also find a copy of it in the red folder you

10 have in front of you there. The reference for the

11 transcript is WIT.003.001.1290.

12 If I could perhaps turn first to page 1291 --

13 A. Yes.

14 Q. -- where you set out quite a number of qualifications,

15 professor. But I don't want to spend too much time on

16 them but can we see that you are a Fellow of the Royal

17 Society of Medicine, the Federation of Surgical

18 Specialist Associates, you are a Fellow of the Royal

19 College of Physicians in Edinburgh and Glasgow --

20 A. Yes.

21 Q. -- and other qualifications that you have set out for us

22 there?

23 A. Indeed.

24 Q. What is your present position?

25 A. I'm retired, but I still hold the Regius chair in the

1 university and I have to teach because of that and
2 supervise postgraduate students.
3 Q. You set out, if we turn to page 1292, a list of
4 different positions that you have held over the years;
5 is that correct?
6 A. Yes.
7 Q. Again, we can look at that for ourselves. But the list
8 includes, for example, past president of the Royal
9 Scottish Society of Arts & Science, the Scottish Medical
10 Legal Society --
11 A. Yes.
12 Q. If you turn to page 1293, you provide a narrative here
13 of your track record --
14 A. Yes.
15 Q. -- beginning close to the beginning in Malta in 1967.
16 A. Yes.
17 Q. But then tracking your career in this jurisdiction?
18 A. Yes.
19 Q. You were in fact appointed Regius Professor of forensic
20 medicine at the University of Edinburgh in 1987 --
21 A. That is right.
22 Q. -- a post you held for quite some considerable time.
23 A. Yes, I retired about 6 years ago.
24 Q. As you have already told us, you still hold the emeritus
25 chair responsibilities for postgraduate teaching and

1 postgraduate supervision.
2 A. Yes.
3 Q. And you are still very busy as a pathologist?
4 A. In two aspects: both as a pathologist and also more
5 frequently nowadays as a forensic medical examiner
6 dealing with clinical cases rather than deceased
7 persons.
8 Q. You tell us on the next page that as a forensic
9 physician for about 35 years you have carried out
10 clinical medical examinations on persons of all age
11 groups who have been injured, overall more than
12 100 persons per annum; is that right?
13 A. Yes.
14 Q. Apart from your practical work you have also contributed
15 to three major textbooks on forensic medicine.
16 A. That's correct.
17 Q. You have also produced other articles and so on.
18 A. Indeed.
19 Q. In relation to major pathological investigations, do you
20 tell us you were in overall charge of the pathological
21 investigations into the Lockerbie aircraft?
22 A. That is correct.
23 Q. And also the El Al plane crash in Amsterdam?
24 A. Yes.
25 Q. And also the Dunblane shooting?

1 A. I was.

2 Q. These were the very major inquiries?

3 A. These were the very major inquiries, yes.

4 Q. Can I turn to the work you have done for this Inquiry,

5 professor.

6 In the folder you have in front of you, you will

7 find two reports that you have prepared: the first in

8 connection with the death of Samuel Carr --

9 A. Yes.

10 Q. -- and the second in connection with the death of

11 Francis McColl. Can we look first at the position of

12 Samuel Carr?

13 A. Yes.

14 Q. In connection with that report, as you tell us, and

15 perhaps I will put -- give you the reference and put it

16 on the screen, it is INQ.001.001.2359. Now, on

17 page 2360, do you set out there a number of documents

18 that you were -- that were submitted to you to assist

19 you in connection with your report?

20 A. That's correct.

21 Q. I think the principal document you had regard to was

22 a post-mortem report --

23 A. Yes.

24 Q. -- carried out in 1964 on Samuel Carr?

25 A. Yes.

1 Q. I can perhaps put that on the screen. It is at
2 PSS.001.001.0306. Again you will find that in the
3 folder and that's at tab 2 in your folder.
4 A. Yes.
5 Q. You are able, I think, to give us a little insight into
6 not only the report but also the author of the report.
7 A. Yes.
8 Q. Can you help us with that?
9 A. Yes, the report was produced by Dr Derry MacDonald.
10 I worked with Derry MacDonald in the Sick Kids in
11 Glasgow several years ago. I knew him personally and he
12 was also one of the earliest paediatric -- solely
13 paediatric pathologist. So he was well renowned in his
14 field and quite eminent in his field.
15 Q. Indeed, you have provided as one of the appendices to
16 your report, appendix 1, the obituary of Dr MacDonald
17 who died on 25 March 2007?
18 A. That's correct.
19 Q. Quite an impressive obituary.
20 A. Indeed, sir.
21 Q. Can we then just look at the pathologist's report and
22 perhaps look at the first page of the report where we
23 have a medical history provided. Can you help with that
24 and tell us what we can take from this?
25 A. What normally happens in a hospital-instructed autopsy

1 is that a doctor will send a request to the pathologist
2 and also a preçis, a very short preçis of the medical
3 history and I think this is what we see. It is signed
4 by Dr C Bullough.
5 Q. The information provided here then, if you just take us
6 through it, we begin by reading that there was a sudden
7 onset of diarrhoea with blood and mucous.
8 A. Yes.
9 Q. Then there is some information given about the blood
10 urea, I think.
11 A. Yes.
12 Q. Which has risen -- I think you tell us that is quite
13 a significant rise?
14 A. The normal blood urea is 20-40mg per cent; this is 720.
15 LADY SMITH: Before we look a little more at the detail, you
16 explained that of course this report of the history is
17 sent by a doctor and we see the report signed by
18 a Dr Bullough in this case. But if we go further up on
19 this document we are told that the child was admitted in
20 June 1964 and was under Dr Shanks.
21 A. Yes.
22 LADY SMITH: So Dr Shanks would have been in charge of this
23 case in the hospital?
24 A. He was a senior consultant paediatrician.
25 LADY SMITH: Where would Dr Bullough fit in?

1 A. He would be one of the junior doctors working with
2 Dr Shank -- at least that's the assumption, that's what
3 normally would happen. Obviously I do not know
4 Dr Bullough but I think that is the assumption which is
5 a reasonable assumption.
6 LADY SMITH: Right, thank you.
7 MR MacAULAY: Is the name Dr Shanks one that you recognise.
8 A. Again, when I worked in the Sick Kids in Glasgow,
9 Dr Shanks was still working there as a consultant.
10 Q. That's why you can tell us that he was indeed
11 a consultant paediatrician --
12 A. Indeed.
13 Q. -- because we don't get that from the report itself?
14 A. No.
15 Q. The treatment that he appeared to have had then, the
16 blood transfusion and the peritoneal dialysis, would
17 that be a standard form of treatment for a boy in this
18 condition?
19 A. He had a very low haemoglobin level: it was 67% and
20 normally it is 100%. So he had a very low haemoglobin
21 and the only way to treat that would be to give blood.
22 The only way in those days you could really try to
23 bring down the blood urea was by a system known as
24 peritoneal dialysis where a tube was inserted into the
25 tummy and flushing the entire contents around the bowel

1 to try and extract the urea from the blood. It worked.
2 I was sent in 1967 to learn about peritoneal dialysis --
3 because it was a very, very early way which one treated
4 uraemia -- in Cardiff. This is the sort of top notch
5 type of treatment in those days.
6 Q. If we then turn to the next page, the first bit of
7 information we are given on page 0307 is that the body
8 was that of a normally developed six-year-old boy
9 weighing 15,761g, which is just over 15 kilos; is that
10 correct?
11 A. Yes.
12 Q. You, I think, have had regard to growth charts to see
13 where that weight would stand for a boy of this age.
14 A. Yes. We managed to get growth charts going back to 1965
15 or 1966, I can't recall. That's the way we tried to
16 match that. Because obviously children have developed
17 in a different way over the last few decades.
18 Q. You are trying to put it in the same time --
19 A. The same timescale as this particular case. Going by
20 that, this child was not developing as normally in terms
21 of his weight as he should have been. One also has to
22 say that he has been quite ill so that might have had
23 an effect on his body weight while he was in hospital
24 during his last illness, but it is a very low weight for
25 a child of this age group.

1 Q. If we perhaps just look at the literature you had regard
2 to, it is LIT.001.001.1929. That's the -- that will
3 come on the screen for you, professor.
4 A. Yes.
5 Q. This is a work by Tanner, Whitehouse & Takaishi.
6 A. Yes.
7 Q. The title is "Standards from birth to maturity for
8 height, weight, height velocity and weight velocity in
9 British children 1965".
10 So that is the time context?
11 A. Yes.
12 Q. I think the particular table you had regard to was at
13 page 1945, if we can turn to that.
14 A. Do I have this document?
15 Q. No, it will come on the screen for you.
16 A. Sorry. Yes, that's right.
17 Q. We are looking at a table for weight for boys. If we
18 run along the horizontal axis do we get the age in
19 years?
20 A. That's correct.
21 Q. And up the vertical axis do we get weight?
22 A. Weight in kilograms.
23 Q. So we can find a spot between 10 and 20 kilograms and,
24 as it were, move across to age 6 and find where on the
25 centile lines this particular weight would lie; is that

1 right?
2 A. Yes, that's right.
3 Q. I think your conclusion was that it was on the about the
4 10th centile --
5 A. That is correct.
6 Q. Can you explain the use of centiles on this type of
7 analysis?
8 A. These particular charts are worked out on a population
9 of what one assumes to be normal children and then it is
10 subdivided into groups, percentages. So, most of the
11 children will fall -- it is a bell-shaped graph. So
12 most of the children will fall in the middle of the
13 graph, around the 58th centile, half of the children
14 should be of this weight. Then you have the lower end
15 of the graph and the top end.
16 The top end are the kids who are developing much
17 faster and the bottom end are those not keeping up with
18 normal development. So 10% is the lower scale,
19 suggesting that this child was not developing -- its
20 weight was not appropriate to his age.
21 Q. This is something we will look at later, but how
22 relevant is that when you are looking at the ability of
23 a child of this age's immune system to deal with
24 infection?
25 A. There is no question at all that a person who is

1 undernourished or malnourished will have a depleted
2 immune system, so he cannot resist infection as a normal
3 child would.
4 Q. But how far you push that in the case of this kind may
5 be quite difficult to say?
6 A. It is individual people will behave in an individual
7 fashion. But in general terms, if the child is not
8 developing normally in terms of its weight, it will be
9 at a lower power in terms of its immunity.
10 Q. If you are looking at something like malnutrition as
11 a possible reason why a child is not developing, is that
12 a process that takes place over time?
13 A. It does indeed, yes.
14 Q. Can you give us any understanding as to what time frame
15 we should be looking at?
16 A. Again, what one is looking at is how much is required in
17 terms of nutrition and how much is being delivered. So
18 depending on the balance between the two, the weight
19 will start ebbing if the nourishment is not appropriate
20 to the amount required. But that obviously is
21 a continuum because sometimes a child may be getting
22 more nourishment than at other times so it is really
23 an end product of a number of factors.
24 Q. Can I then go back to the post-mortem report with you,
25 professor?

1 A. Yes.
2 Q. The first section of the report, I think, involves
3 an examination of the brain.
4 A. It does.
5 Q. Can you summarise what the findings were?
6 A. Well, I think the first thing is the brain was heavier
7 than it should be. The reason why it was heavier is
8 because it was swollen. We referred to that as "general
9 oedema"; it means the brain was swollen. Indeed, in
10 addition to that, there was a bleeding into the brain of
11 several days' duration. The bleeding was associated
12 with softening of the brain, so we have a number of
13 factors in the brain indicating that the brain has been
14 damaged over a period.
15 Q. If we then move on to the second page -- the next page,
16 which is at 0308, where there is some examination of the
17 kidneys carried out.
18 A. Yes.
19 Q. What did that disclose?
20 A. The kidneys looked all right to the naked eye but when
21 they were examined under the microscope, there was
22 an abnormality of the kidneys which at the time was not
23 explainable. They hadn't seen very much like it before
24 that.
25 Q. I think it is the case that Dr MacDonald did consult

1 with colleagues --
2 A. Indeed.
3 Q. -- to see whether they could work out what this was.
4 A. And they didn't help him either. It's obviously --
5 medical knowledge progresses over the years and at that
6 time he had his own experience, he tried to get the
7 experience of other people, perhaps more experienced
8 than he was in kidney disease, and they got nowhere.
9 They couldn't explain what they were seeing.
10 Q. I think, with the benefit of time going by and science
11 developing, you are able to explain what was happening.
12 A. I think we can have a very good stab at what happened in
13 this particular instance in relation to the medical
14 history and the findings in the kidney.
15 Q. Can you perhaps just take us through that, professor?
16 A. I am sure we have all heard about children going on
17 field trips to farms and two weeks later developing
18 an intestinal infection and very soon after that their
19 kidneys pack up. This is because they have acquired
20 from the animals they had been in touch with a form of
21 bug, a Escherichia coli, E. coli, which has a particular
22 tendency to damage the kidneys. It is a very severe
23 infection, very acute damage to the kidneys being done,
24 and some kids succumb to the infection even in this day
25 and age.

1 Q. There is a suggestion in this case that Samuel Carr had
2 contact with a dead rat.
3 A. Yes.
4 Q. You are aware of that?
5 A. Yes.
6 Q. Could that be relevant then to this whole picture?
7 A. Well, to be frank, I wasn't aware that dead rats carried
8 this particular bug, but I have looked into the
9 literature and there's good evidence that quite a number
10 of rats in a sort of rural agricultural setting will
11 carry this particular bug in the blood, in their system.
12 So any person handling a rat with this infection can get
13 the infection himself, acquire it from the rat.
14 Q. How do you see the mechanism here then? Let's start
15 with contact with a rat that may have been the carrier
16 of the infection. Where does the infection go, so far
17 as the human being is concerned?
18 A. The rat will have it in his guts, in the guts of the
19 rat, and perhaps on skin, on pelt which has been smeared
20 with intestinal contents. A person handling the rat,
21 alive or dead, may become contaminated with the faecal
22 material or with the blood of the rat and become
23 infected that way -- obviously licking the finger or
24 touching the mouth after being in contact with the rat.
25 Q. And where would the infection then originate insofar as

1 someone like Samuel Carr? Where would it start?
2 A. It would start in the intestinal tract.
3 Q. Do you see evidence of that from the diarrhoea and blood
4 in the diarrhoea?
5 A. Yes, we are told he had a bout of diarrhoea and what is
6 more he had mucus and blood in his stool, which would
7 suggest a very severe intestinal infection and indeed an
8 E. coli infection of the type we are talking about can
9 do just that.
10 Q. And then what?
11 A. Then obviously as the body is losing fluids, is losing
12 things like potassium, electrolytes, the kidneys will
13 start to fail. Furthermore, this particular bug
14 produces a poison, a toxin which is nephrotoxic which is
15 directly damaging to the kidneys. So you have a double
16 assault: you are losing fluids, you are losing
17 electrolytes, and you are also having your kidneys being
18 poisoned by toxins produced by this organism.
19 Q. Moving on from the attack on the kidneys, if you like,
20 how does that then impact upon the brain?
21 A. The kidneys will indeed fail and one of the effects of
22 kidney failure is that your blood pressure rises. One
23 of the effects of any form of renal damage is a rise in
24 blood pressure and one of the places where the blood
25 pressure may go beyond what the body can cope with is in

1 the region of the brain and the brain may develop
2 hemorrhages and worse as a consequence of raised blood
3 urea and renal failure.
4 Q. Is that what you see here in relation to the examination
5 of Samuel's brain?
6 A. It appears to be the most likely series of events that
7 fits the bill.
8 Q. The syndrome you have been discussing, does that have
9 a name, the post-diarrhoeal problem you have identified?
10 I think you have told us it is called HUS.
11 A. Yes, haemolytic uraemic syndrome. Because you have:
12 "haemolysis", where the blood cells also start falling
13 apart; and "uraemic" because blood urea -- the kidneys
14 fail; "syndrome" as it is a collection of these various
15 things.
16 Q. You have I think identified some literature in
17 connection with that in your report.
18 A. Yes.
19 Q. Let's perhaps look at that. INQ.001.001.2376. Here we
20 read about this syndrome, HUS. The first paragraph:
21 "HUS was first described in 1955 but was not known
22 to be secondary to E. coli infections until 1982."
23 That is really after Dr MacDonald's involvement with
24 Samuel Carr?
25 A. Indeed. Dr MacDonald would not have known, neither

1 anybody of his age group would have known about this.
2 Q. But you go on to say:
3 "It is now recognised as the most common cause of
4 acute kidney failure in infants and young children."
5 A. Yes.
6 Q. Well, having gone off script to some extent, can we go
7 back to your report then, professor, on page 2364. You
8 have a section where you deal with what's headed the
9 interpretation of the autopsy findings. Can you just
10 take us through that. I mean you begin by telling us
11 that:
12 "Death was said to have been the result of a diffuse
13 brain condition."
14 We have discussed that to some extent.
15 A. Yes.
16 Q. You then go on to say -- and you highlight this:
17 "I am in no doubt at all that the brain hemorrhage
18 seen in this instance was not traumatic in origin ..."
19 A. That is correct.
20 Q. There is no doubt about that?
21 A. It is not in the right sort of situation for trauma. It
22 doesn't fit a traumatic picture of any variety.
23 Q. As you have told us already:
24 "[It] represents the secondary result of, and
25 an accompaniment to, a widespread infection of the brain

1 substance associated with multiple septic thrombi and
2 abscess formation."
3 A. Yes.
4 Q. On the next page, 2365, at letter (c), again we touched
5 upon the relevance of the immune system, but what you
6 say there is that:
7 "For a disseminated fungal/yeast infection to occur,
8 one would have to suggest a general compromisation of
9 the child's immune system or a condition leading to
10 diffuse immune deficiency. A normal immune system would
11 not allow a dissemination of a fungal infection to
12 occur."
13 Can you elaborate upon that?
14 A. What I think we haven't mentioned is that in addition to
15 the renal problems, in addition to the brain problems,
16 this young boy had a decreased, a diminished immune
17 system. As a consequence of which, organisms which
18 normally can be dealt with quite fairly, such as fungal
19 and yeasts, take over. So in this particular instance,
20 in addition to the renal conditions and the intestinal
21 conditions, there was also a diffuse fungal infection
22 because of the diminished immunity.
23 So because his immunity was decreased, for a variety
24 of reasons related to this acute illness, he was prone
25 to dissemination of an infection which normally doesn't

1 cause major problems.
2 What we know about this child is that his thymus
3 gland, which is the most important gland in terms of
4 immunity in children, and his spleen were recorded as
5 being normal at autopsy. So this suggests that there
6 was some other form of immune compromisation: presumably
7 the renal failure, possibly aided and abetted by the
8 poor general condition of this child.
9 Q. Because you go on, if you go on to the next page, 2366,
10 at letter (d) to again mention malnutrition as being
11 relevant to an acquired immune deficiency.
12 A. Yes.
13 Q. You are distinguishing an acquired autoimmune deficiency
14 from a congenital type immune deficiency?
15 A. Correct.
16 Q. We have already talked about the rat and its potential
17 relevance. Do you tell us towards the bottom of that
18 page that around 40% of the rat population is infected
19 with E. coli?
20 A. So I discovered from the literature. It is not
21 something I knew but having looked into it, that is what
22 has been referred to in the literature.
23 Q. Therefore you say that had this child been touching or
24 poking a dead rat with a stick and perhaps in the
25 process of this his hands and later his mouth were

1 contaminated, infection of E. coli could have been
2 transmitted to him in this manner?
3 A. That's correct.
4 Q. That is a perfectly feasible scenario?
5 A. Indeed, sir.
6 Q. Can I then look at page 2363 of the report, where you
7 have a section dealing with trauma. Because you were
8 provided with information that at a time prior to death
9 that Samuel Carr had suffered a traumatic event.
10 A. Yes.
11 Q. I think you were provided with extracts from statements
12 to that effect.
13 A. I was, yes.
14 Q. The problem I think is that we don't have a clear time
15 frame between that happening and the death itself. But
16 in relation to traumatic events such as punching,
17 kicking and so on, normally would you expect to find
18 evidence of that on the individual?
19 A. If it was severe enough, bruising, even severe bruising,
20 usually dissipates away by two to three weeks from when
21 it arises, but it may last longer if it is more diffuse
22 and more deep. Bone fractures take minimum of four
23 weeks to heal, so had there been bone fracturing of the
24 skull or elsewhere, they should have been visible to the
25 pathologist, albeit in those days the bodies were not

1 X-rayed. Normally nowadays the body of the child will
2 be X-rayed prior to autopsy to look for fractures. It
3 was not done in those days, it wasn't the sort of thing
4 that was done, but the pathologist during the procedure
5 would have noticed any fractures of ribs, for example,
6 spinal column, skull, et cetera, and none were found.
7 Q. In relation to bruising, I think as you tell us in fact,
8 it really is time dependent. In a young child does
9 bruising tend to disappear more quickly than say in
10 an older person?
11 A. In general terms that is correct. The younger you are,
12 the quicker you heal. Bruising is a form of trauma and
13 it has to be healed by normal processes of repair in the
14 body.
15 Q. But in any event, professor, you are in no doubt that
16 the cause of death was not related to trauma but to this
17 type of mechanism you have set out?
18 A. Yes, we have a good pathological series of events which
19 could explain the death and the findings on the skull
20 are not those of a traumatic head injury.
21 Q. Can I then take you to your conclusions for this report,
22 professor, at page 2368. Perhaps you can just take us
23 through these conclusions; you have them lettered (a),
24 (b), (c), and (d).
25 A. I think we need to --

1 Q. Wait for the screen?
2 A. Yes, please. (Pause). Yes.
3 Q. Can you just perhaps summarise for us what your
4 conclusions are?
5 A. Yes. I think in (a) I say:
6 "Based on the incomplete medical evidence available,
7 it appears that trauma, following on an alleged assault,
8 did not have a direct or indirect part to play in the
9 death of this child."
10 In (b) he say:
11 "Given his low body weight, it is a viable
12 possibility that he may have been suffering from some
13 degree of malnourishment. This would have predisposed
14 him non-specifically to infection and also decreased his
15 general resistance to infection once any infection had
16 become established in him."
17 I think something we have already rehearsed.
18 Q. Yes.
19 A. Under (c) I say:
20 "There is evidence to suggest that he may have been
21 involved in touching or poking a dead rat some time
22 before he took ill. This could have been the source of
23 an infection with an E. coli organism which in turn
24 could have resulted in severe acute kidney failure."
25 Q. Moving on to page 2369 -- if we wait for the technology,

1 professor -- at (d).

2 A. "Such catastrophic kidney failure would clearly have

3 radically decreased his general immunity and his ability

4 to combat infections and could have caused him to become

5 more prone to other secondary infections, not least

6 opportunistic infections due to fungi and yeasts."

7 Under (e) I say:

8 "The pathological change identified in this child's

9 brain at autopsy strongly suggests that such

10 a disseminated opportunistic infection, complicated by

11 vascular thrombosis of the vessels supplying blood to

12 the brain, with secondary hemorrhage within the brain,

13 and local softening, and the development of such

14 clinical syndromes as convulsions and squint."

15 What I'm saying simply here is that in addition to

16 his kidney problem, he had this infection all over his

17 body, of which there is evidence at post-mortem, and one

18 of the complications of such infection is that the blood

19 clots spontaneously within vessels for no other reason.

20 This will cause damage to the brain and softening of the

21 brain.

22 Q. Perhaps, finally in connection with this particular

23 case, if I could take you to a short report prepared by

24 two other consultant paediatric pathologists. You will

25 find this at PSS.001.001.0262.

1 I think this is a document that you also had sight
2 of --
3 A. I had indeed.
4 Q. -- at the time of preparing your report?
5 A. Yes.
6 Q. You will see it is a report dated 14 June 2016 by
7 Dr Penman and Dr French?
8 A. Yes.
9 Q. Generally speaking do you agree with the views expressed
10 in the report?
11 A. Entirely, yes.
12 Q. Perhaps, finally, if I could ask you to look at the
13 death certificate for Samuel Carr. This is at
14 INQ.001.001.2381. The bit that's not blacked out, you
15 will see that is the entry in the Register of Deaths for
16 Samuel Carr. Again I think you were sent a copy of
17 this. You will see that the cause of death in box 6 is
18 said to be "cerebral hemorrhage"?
19 A. Yes.
20 Q. Is that an acceptable description of the cause of death?
21 A. Yes, because the child died with convulsions and loss of
22 consciousness and there was evidence of cerebral
23 hemorrhage at post-mortem. Obviously, there are many
24 causes of cerebral hemorrhage so it is a very blunt
25 conclusion but an adequate conclusion.

1 Q. Thank you.
2 Now, the other case you were asked to --
3 LADY SMITH: Just before we go to that, Professor Busuttil,
4 while you have still got your conclusions in front of
5 you on the Samuel Carr case. You refer in (b) to the
6 possibility that the child was suffering from
7 malnourishment --
8 A. Yes.
9 LADY SMITH: -- and that would have predisposed him to
10 infection.
11 A. Yes.
12 LADY SMITH: If for example you take a small malnourished
13 six-year-old child who already has an E. coli infection
14 and that child is assaulted violently by an adult, what
15 is that likely to do to his ability to resist the
16 infection from which he is suffering?
17 A. I don't think there is a direct link between trauma,
18 even severe trauma, and immune regulation. The two do
19 not go together. So, even if one is severely
20 traumatised, acutely, there will be no depletion of the
21 immune system. As time passes and the body is trying to
22 repair things, the immune system will fall, but
23 immediately, close to the time of the trauma, there is
24 no reaction of the immune system as a direct result of
25 the trauma.

1 LADY SMITH: Right, I have got that. Sorry, from what you
2 have just said, are you suggesting -- and let's think of
3 this in layman's terms -- the body has got a lot more
4 work to do as time passes -- no immediate effect, but if
5 there is trauma to deal with from the assault, as well
6 as handling this vicious infection that has affected the
7 child, it is much harder work?
8 A. It is, yes. It is a question of the straw that broke
9 the camel's back. The more you add on, the more likely
10 it is that the body will not be able to recuperate.
11 LADY SMITH: Thank you.
12 MR MacAULAY: I was going to move on then, professor, to
13 look at the short report you have prepared in connection
14 with Francis McColl, who was the other child you were
15 asked to consider. If we can perhaps get your report on
16 the screen and in front of you, it is INQ.001.001.2675.
17 A. Yes.
18 Q. Again, you had available to you here an autopsy report
19 that had been carried out in connection with this
20 particular child and if I could put that on the screen,
21 it is at INQ.001.001.2482. I think it is tab 5 in your
22 red folder.
23 Again, I think you may not have known the
24 neuropathologist who did the autopsy, but I think you
25 did know one of the pathologists who were involved in

1 this case.
2 A. I don't know who the original general pathologist was.
3 Dr Tony Maloney again is contemporary to me in the
4 Western General Hospital in Edinburgh and I knew him
5 quite well. Again, a very eminent neuropathologist.
6 Q. So far as the narrative is concerned, do we read on the
7 first page of the autopsy report that the post-mortem
8 took place on 15 August 1961?
9 A. Yes.
10 Q. And the child had died on 12 August 1961?
11 A. Yes.
12 Q. We can read, it is not very clear, that the patient was
13 struck on the left side of the head by a golf ball?
14 A. Yes.
15 Q. He was admitted to Law Hospital on 5 August 1961:
16 "... unconscious and responding to painful stimuli,
17 irritable."
18 A. Yes.
19 Q. That is the background, and I don't think it will make a
20 difference as far as blunt trauma is concerned, but the
21 suggestion maybe it was a golf club rather than a golf
22 ball that struck the child.
23 A. Any blunt object hitting the head with force could have
24 produced the injuries found on this child.
25 Q. Looking then to your commentary on this particular case,

1 professor, if we go to your report at INQ.001.001.2675,
2 do you essentially summarise that there had clearly been
3 blunt force impact against his left temple?
4 A. His death is directly resultant from blunt force trauma
5 to the head.
6 Q. And that's what the autopsy concluded?
7 A. The autopsy concluded that indeed the trauma had
8 produced severe damage around the brain in terms of
9 hemorrhage of the brain with secondary pressure effects
10 on the brain.
11 Q. I think you thought that this would be a case where the
12 procurator fiscal -- there would have been a report made
13 to the procurator fiscal about the death?
14 A. During my time that would be invariably the case that
15 a traumatic death in a child would have been a case
16 reportable to the procurator fiscal.
17 Q. I think we understand that that did happen. If I could
18 ask you to look at this document INQ.001.001.3127. That
19 would appear to be a register of corrected entries for
20 this child. Can you see towards the bottom -- it is not
21 very clear but perhaps we can just make that a bit
22 bigger. Can we see that it has been to the procurator
23 fiscal's office and can we see the correction that has
24 been made under reference to cause of death, being
25 "a left extradural haemorrhage", the word "accidental"

1 has been added --
2 A. That has been added underneath, yes.
3 Q. So does it appear that there has been a report to the
4 procurator fiscal who has decided it is an accidental
5 death and no further action may have been taken?
6 A. I think that's a fair assumption.
7 MR MacAULAY: Very well, professor. Thank you very much
8 indeed for coming to help us and give your evidence.
9 I haven't received any written questions for the
10 professor, my Lady, and I don't know if there are any
11 questions for him.
12 LADY SMITH: Thank you. Could I check whether there are any
13 outstanding applications for questions? No. Thank you.
14 Professor Busuttil there are no more questions for
15 you. I'm very grateful to you for the work you have
16 done in relation to both of these cases. It's been of
17 great assistance to the Inquiry and I'm now able to let
18 you go.
19 A. Thank you, my Lady.
20 MR MacAULAY: My Lady, we have made very good progress this
21 morning, as it turns out. The next witness was
22 programmed for after the break, so perhaps, my Lady, we
23 can contemplate rising a bit earlier and coming back
24 at --
25 LADY SMITH: 11.45 am? We will rise now and return at

1 11.45 am.
2 (11.10 am)
3 (A short break)
4 (11.45 am)
5 LADY SMITH: Yes, Mr MacAulay.
6 MR MacAULAY: My Lady, the next witness I would like to call
7 is Mrs Janet Bishop.
8 MRS JANET BISHOP (affirmed)
9 LADY SMITH: Thank you. Do sit down and make yourself
10 comfortable.
11 Mr MacAulay.
12 Questions from MR MacAULAY
13 MR MacAULAY: My Lady.
14 Mrs Bishop, are you Janet Mary Bishop?
15 A. I am.
16 Q. How old are you?
17 A. 62.
18 Q. I want to put your CV on the screen for you. If you
19 look at the red folder, it is item 1 in the red folder
20 and so it is at WIT.003.001.1269.
21 You provide us with some details about your
22 secondary education and your employment and I want to
23 pick up from the point in time when you became involved
24 in genealogy.
25 I understand from looking at your CV that you did

1 a genealogical course in connection with
2 Stirling University, 1998 to 1999?
3 A. That's correct.
4 Q. Before that though had you had an interest in genealogy?
5 A. About two years before that I became interested in my
6 own family history; that's the usual way in.
7 Q. But having taken that course, can we see that you then
8 became self-employed and you describe yourself as
9 a professional genealogist from 2000 to the present?
10 A. That's correct.
11 Q. In connection with your interest and positions, you have
12 been a member of the Association of Scottish
13 Genealogists and Researchers in Archives, otherwise
14 known as ASGRA, since 2000; is that right?
15 A. That's correct.
16 Q. Are you now the chairman of that particular body?
17 A. I am.
18 Q. What does that body do?
19 A. Well, we are an association of self-employed
20 professional genealogists, each running our own
21 practices, and we do genealogy research, we do
22 historical research, legal research.
23 Q. You carry out your own practice but do you liaise with
24 other members in the same field?
25 A. Yes, very much so because we are working in the same

1 archives and research offices.
2 Q. You also tell us that you have been a member of the
3 Genealogy Programme Board attached to
4 Strathclyde University since 2010.
5 A. That is correct.
6 Q. What does that involve?
7 A. Really, I sit in on the programme board meetings. It is
8 a distance learning online course, right up to masters.
9 I suppose we give feedback. We get sample reports from
10 the university, we assess them, we give feedback, and we
11 help steer the course.
12 Q. You also provide us with some further information about
13 other membership connections that you may have; is that
14 right?
15 A. That's correct.
16 Q. Can I just ask you, if you can, in a general way to tell
17 me what genealogical research entails?
18 A. Well, it entails researching one person's paternal and
19 maternal family line back as far as you can go, as far
20 as records allow. Basically.
21 Q. In that connection then do you develop an expertise in
22 looking for and looking at records?
23 A. Yes.
24 Q. Are there particular places in the country where you can
25 go to look at records?

1 A. There are. Every county has its regional archive or
2 heritage centre or local studies -- it depends on how
3 keen the council is to promote it. But centrally the
4 Scotland's People Centre, as it is now called, holds the
5 Scottish records and that would be the beginning -- the
6 starting point really for any genealogical study because
7 that holds records of statutory events.
8 Q. And you have described it as the Scotland's People
9 Centre but was that formerly Register House at
10 Edinburgh?
11 A. That's correct.
12 Q. Insofar as your presence here today is concerned, you
13 provided the Inquiry with a statement; is that right?
14 A. That is correct.
15 Q. Perhaps I can just look at that first of all. That's
16 WIT.001.001.2393 and you will find that at tab 2 in the
17 red folder. It will also come on the screen in front of
18 you.
19 There is one correction you want to make to the
20 statement before I move on and that is at paragraph 3,
21 where you want to correct who first contacted you in
22 relation to the work that we are going to talk about.
23 Whereas there it suggests that the first contact was
24 the Sunday Post, in fact I think you say it was the BBC
25 who made first contact with you.

1 A. That's correct, it was a BBC radio producer.
2 Q. But if we turn then to page 2397 of the statement,
3 that's the last page, can you confirm for me,
4 Mrs Bishop, that you have signed the statement?
5 A. I have.
6 Q. Subject to what we have just touched upon, do you say
7 that you believe the facts stated in the statement are
8 true?
9 A. I do, yes.
10 Q. Then can we just go back then to how you became
11 involved, as we now know, in looking at the deaths in
12 particular of children who had a connection with Smyllum
13 in Lanark. You have indicated it was the BBC that first
14 of all made contact with you.
15 A. That's correct.
16 Q. What was the purpose of that contact?
17 A. It was by telephone and I was asked whether -- well, the
18 very first thing I was asked was how would someone go
19 about gaining access to the death registers and
20 searching the death registers. I replied really that
21 that wasn't possible, which it really wasn't possible,
22 as browsing is not allowed. So, it was then decided
23 that I would do the search because being a regular
24 visitor to the Scotland's People Centre, I did know how
25 to search the registers. He said what they were looking

1 for was a search of the Lanark -- he didn't actually say
2 Lanark, I correct that. The death records relating to
3 deaths at Smyllum Orphanage or children who lived at
4 Smyllum.
5 Q. So that was the general remit that you were being asked
6 to carry out?
7 A. Yes.
8 Q. The Sunday Post became involved at a point in time
9 because we know there was a Sunday Post article in due
10 course.
11 A. The Sunday Post -- from my point of view, the
12 Sunday Post became involved after I had completed my
13 report.
14 Q. Was that your final report or an earlier report?
15 A. It was the first report.
16 Q. Because I think, as we will see, you completed two
17 reports, as you say, the first report and then there was
18 a final report.
19 A. There would be a final report.
20 Q. Did you also do a feasibility study to give
21 an indication as to what might be involved in the work?
22 A. I did the feasibility study free of charge at the
23 beginning because I myself, I didn't really understand
24 what I was going to be looking at and what I was going
25 to find. So I reported on that. I did a couple of

1 hours.
2 Q. But then coming, I think this was, to May 2017, as you
3 tell us in your statement, you were instructed to
4 conduct an extensive search of death records contained
5 in the death registers for the district of Lanark, is
6 that correct --
7 A. That is correct.
8 Q. -- relating to Smyllum?
9 A. Yes.
10 Q. Can you then just describe for me what was involved in
11 that task? What did you have to do?
12 A. The time period that we were looking at was 1864 through
13 to 1981. It involved gaining access to the death
14 register for Lanark. I discovered it was Lanark;
15 I didn't know where Smyllum was and I wasn't given that
16 information. But it was the Lanark district statutory
17 death registers for that period and it also involved
18 going through each record.
19 Q. You give us some understanding in your statement what
20 that involved but can you just help me with that. What
21 did you actually have to do when you went to
22 Register House, as it then was, or the Scotland's People
23 Centre to do this research?
24 A. Well, obviously, the system now is computerised and
25 I have a permanent seat, so I was well used to this.

1 Obviously I did not have -- I had some names, I had been
2 provided with some names, but I did not have any names
3 to get in. So I took one name and got into the register
4 in one year. All it is is a simple process of going --
5 once you know how to do it, you can change the toolbar
6 and go page by page to get from record 1 in January to
7 the December.
8 Q. So if we start with, as you mentioned, 1864, would you
9 start from that point in time and just work your way up
10 to 1981?
11 A. Yes. These records are obviously digitised year on year
12 so I had to go into 1864, find page 1, and work all the
13 way through. There are three on each page.
14 Q. What were you looking for?
15 A. I was looking for deaths of children under 18, who
16 either died at Smyllum or who died elsewhere but were
17 given -- they were registered as living at Smyllum.
18 That could be Smyllum Orphanage, Smyllum school -- there
19 were various names given. I recorded them all.
20 Q. You tell us in your statement, Mrs Bishop, that this
21 involved looking at around 15,000 records over that
22 whole period.
23 A. That's correct.
24 Q. It was quite an extensive piece of work?
25 A. It was.

1 Q. In addition to that work, were you also provided with
2 a specific list of names that were of interest?
3 A. I was sent by email some pages which really I didn't
4 know what they were. I didn't know where they had come
5 from. I did not know if they were burial records,
6 admission records -- there was some reference to
7 admission records. I did not know what they were and
8 there were some names on them, which did help me get
9 into some of the years.
10 Q. But were these names that weren't covered by the Lanark
11 death register and were in relation to other areas?
12 A. Well, no. Initially what I was sent were ones that were
13 connected with Lanark. Afterwards, once the Sunday Post
14 became involved, I was then sent details of, well, names
15 basically and dates and I was asked to find these and
16 they actually turned out to be in other districts.
17 Q. I mean I think you mention, for example, districts like
18 Carluke, north Glasgow and Edinburgh as being districts
19 that were involved with these particular deaths?
20 A. Yes, obviously to do that I had to have the names. It
21 wouldn't have been apparent to me.
22 Q. But again were you looking to see that there was
23 a connection with Smyllum --
24 A. I was.
25 Q. -- on the death certificates?

1 A. Yes.
2 Q. Can I then move on from that background and look at the
3 reports that you prepared. The first one I want you to
4 look at is at INQ.001.001.2060. I think that may be at
5 tab 4 in your folder. This is quite an extensive
6 document. If I just look quickly at it, we start
7 towards the top at 1864 deaths; is that right?
8 A. That's correct.
9 Q. If we move to the very last page, and page 2105, is the
10 last entry we have in this document for 1961?
11 A. That's correct.
12 Q. You have numbered it 412. Does that mean there are 412
13 entries in relation to deaths in this document?
14 A. Yes, that is correct.
15 Q. While we have that on the screen -- we have it on the
16 screen and I don't know if we can highlight it or get it
17 closer or not. Can we see the last entry you have is in
18 relation to Francis McColl? The information that you
19 have provided there, have you taken that from the death
20 certificate?
21 A. It is not from the death certificate, no. It is from
22 the register; that's a different thing entirely. It is
23 the registrar's register.
24 Q. But what you get from that is, for example, the usual
25 residence being Smyllum House; you have got that?

1 A. That is correct, yes.
2 Q. You have also got his date of death and his age?
3 A. That's correct.
4 Q. And indeed the cause of death?
5 A. The cause of death, but that has been amended. That
6 cause of death is not -- we amended that.
7 Q. It should have been extradural?
8 A. Yes.
9 Q. But leaving that aside the cause of death --
10 A. The cause of death is there.
11 Q. -- is recorded?
12 A. Yes.
13 Q. Am I right in thinking this is the first report then
14 that you prepared following upon the work that you did?
15 A. This would have been the second stage because
16 Francis McColl would have come in after the Sunday Post
17 became involved because this is an Edinburgh death and
18 I didn't include these because initially I was asked to
19 do Lanark.
20 Q. I will take you then to the next document and see how
21 this fits in. It is INQ.001.001.2106. We are now
22 looking at a document headed "Genealogy Scotland", with
23 reference to yourself. Can we then again see that we
24 have a list of deaths beginning in 1864?
25 A. That's correct.

1 Q. If we go to the last page once again, for this document
2 on page 2175, do we see here the last entry is for
3 Samuel Carr for 12 June 1964?
4 A. That's correct.
5 Q. I think before that we see the reference to
6 Francis McColl.
7 A. That's correct.
8 Q. How does this document fit in with the other document
9 that we looked at?
10 A. This came afterwards. This was a tidying-up document.
11 Q. One of the differences between the two was -- whereas in
12 the first document you have numbered the entries from 1
13 to 412, I think you don't actually number the entries in
14 this second document.
15 A. I don't think I -- I'm not aware that I actually
16 numbered those.
17 Q. I see.
18 A. I would not have numbered those. I will tell you why:
19 you will see in the first one I gave the entry at the
20 very end. I gave the references to the death registers
21 and I gave the entry. I wasn't counting these as I went
22 along, so I had no need to number them. So someone else
23 has numbered them.
24 Q. Leaving that aside, the second document we have looked
25 at is the final one, if you like?

1 A. It is the final one, yes.
2 Q. If we go to page 2172. Do we have a section there
3 headed "Appendix"?
4 A. That's correct.
5 Q. How does that fit into the document? What's the
6 background to this?
7 A. This was the result of a second piece of research I did
8 on particular names, which came from the Sunday Post.
9 Q. So this is the list of names you mentioned before, is
10 it?
11 A. This is what I was supplied with after my report had
12 gone in.
13 Q. So names, if we turn to page 2175, like Francis McColl
14 and Samuel Carr, were on the list that had been provided
15 to you by the Sunday Post?
16 A. Yes and I had made my -- I have made notes as to why
17 they were not on my list and there are various reasons
18 why I wouldn't have included them: they did not seem
19 part of my remit. But I was supplied with these names.
20 Q. Again, if we look at page 2175. We already looked at
21 Francis McColl, but the reference to Samuel Carr, again
22 the usual residence is Smyllum Park Home in Lanark.
23 A. Yes.
24 Q. If we go to page 2170, the first point I want to take
25 from you is this: can we see in 1970 there's one death

1 recorded and it is an Annie Brennan, who is aged 93; is
2 that correct?
3 A. That is correct.
4 Q. Did you also include in your tables not only children,
5 but also adults who had died with a Smyllum connection?
6 A. I did at the outset because I hadn't, I think at that
7 time, been specifically asked -- the brief was a bit
8 woolly and I had not been specifically asked to exclude
9 any particular age group. I think the age 18 did come
10 afterwards.
11 Q. But in any event, we have an entry there. There will be
12 other entries, I would imagine then, in your list of
13 adults who died.
14 A. Yes, there were. There were obviously some Sisters.
15 Q. If you look at the very last entry, at 2171, can we see
16 that the last entry is about the time Smyllum was
17 closing at 1981 and can we see it is Bridget Hawkins who
18 was a Sister of Charity?
19 A. That's correct.
20 Q. If we go back to page 2170, can we see that the last
21 child who died with a connection with Smyllum is a child
22 by the name of Patricia Lawson Meenan?
23 A. Yes.
24 Q. The date of death, according to the entry you have
25 provided, is 10 October 1969.

1 A. That's correct.
2 Q. She died at Killearn Hospital in Killearn, although here
3 we see the usual residence is given as 141 Gallowgate,
4 Glasgow.
5 A. That's correct.
6 Q. What did you see the Smyllum connection to be here?
7 A. I saw absolutely no connection and that's why I have got
8 an asterisk. I was given that name -- I think this was
9 the final name that I was given -- and I was given
10 a newspaper article in relation to this child but there
11 was no connection at all in the register to indicate
12 Smyllum.
13 Q. But can you -- sorry, carry on.
14 A. I did include it because I was asked to.
15 Q. Did we see that so far as the cause of death is
16 concerned that that's described as being:
17 "Fracture of the skull, contusions and laceration of
18 the brain"?
19 A. Yes.
20 Q. If we go back to page 2175, where you have the entries
21 for, first of all, Francis McColl, have you noted there
22 that the informant was his brother John McColl?
23 A. Yes, I have.
24 Q. And for Samuel Carr have you noted the informant to be
25 his mother, Mary Ann Dick or Carr?

1 A. For Samuel Carr?
2 Q. For Samuel Carr.
3 A. No, the informant was the child care officer.
4 Q. You are quite right, my mistake. I think we note that
5 on the death certificate. Thank you.
6 You have mentioned the Sunday Post on a number of
7 occasions, Mrs Bishop. We are aware there was
8 a Sunday Post article following upon this search you
9 carried out.
10 If we could look at INQ.001.001.3114. That's at
11 tab 8 in your folder. We see in this article a list of
12 names and the list begins on the first page of the
13 report. If we go through the next page, through the
14 next page, through to page 3117, can we see the list
15 continues. If we look at the last column of the list,
16 can we see that there is a point in time when what is
17 being recorded are names from 1900 onwards? Would you
18 look at the last little column on the right-hand side.
19 A. You mean on 3120?
20 Q. 3117.
21 A. We are still on 3117. (Pause)
22 Q. If I could get the camera to move to the bottom
23 right-hand side of the screen.
24 A. Right.
25 Q. The column on the right-hand side, can we just highlight

1 that?
2 A. Right, okay.
3 Q. Can we see that the names of deaths begin, three from
4 the bottom, at 1900?
5 A. Yes.
6 Q. Thereafter the list of names that goes on on that page,
7 and the subsequent pages are in respect of a period
8 post-1900?
9 A. Okay, right. Yes.
10 Q. Would these names have been taken from the work you did?
11 A. I assume so. I have to say I didn't study the list.
12 I didn't study the newspaper at all, yes.
13 Q. Can we see on the basis of this article that there were
14 many, many children recorded as having died at Smyllum
15 according to the press article --
16 A. Yes.
17 Q. -- post-1900?
18 A. Yes.
19 Q. On behalf of the Inquiry, were you asked to go and
20 inspect the burial records at St Mary's parish church in
21 Lanark?
22 A. Yes, I was.
23 Q. Perhaps I can then ask you to look at the report that
24 you prepared for the Inquiry? That's at
25 WIT.003.001.0825. That's probably at tab 6 in your

1 folder.

2 Can we see this is a report dated 6 November 2017,

3 prepared by you?

4 A. Yes.

5 Q. What did you do when you went to St Mary's Church in

6 Lanark?

7 A. I spoke with the priest and I was shown into a room

8 where he presented me with the St Mary's burial register

9 and I was allowed to look at it.

10 Q. What did you understand that register to be? What was

11 it recording?

12 A. The register was recording all the burials in St Mary's

13 Cemetery.

14 Q. Did you understand that St Mary's Cemetery at Smyllum

15 was connected to the Catholic Church at Smyllum?

16 A. Yes.

17 Q. I think you tell us in this report, Mrs Bishop, that you

18 viewed the registers on 4 November 2017.

19 A. 6 November. 4th November? I did view it on the 4th.

20 Yes.

21 Q. Yes, the report is dated the 6th --

22 A. 4th November. The report is dated the 6th and I viewed

23 it on the 4th, yes.

24 Q. Insofar as people who have been recorded as having been

25 residents at Smyllum, what did you find in the burial

1 records? I'm focusing on children who were under 18.
2 A. For children under 18, I found 16 burials of
3 under-18-year-old children who had been residents at
4 Smyllum and their burials were in a section that had
5 been set aside for Smyllum.
6 Q. You were focusing, I think, on a particular period of
7 time?
8 A. 1900 to 1981, yes.
9 Q. So just to be clear then, for that period, insofar as
10 the burial records are concerned, there is a record of
11 16 children from Smyllum having been buried in the
12 cemetery?
13 A. That's correct.
14 Q. I will come back to that, but can I just understand the
15 general set up with regard to the cemetery and how
16 burial plots were recorded in the register? Do you
17 follow me, can you help me with that?
18 A. I was shown a plan of the cemetery -- because I haven't
19 actually been to the cemetery, I was shown a plan of it,
20 and it was divided into sections, as most cemeteries
21 are, and they all had names. In the register, the
22 burial register, a name of the buried person was given,
23 the date of burial, and also which section they were in
24 and which lair.
25 Q. Do I take it from that, that on the basis of the burial

1 register, it would be possible to identify where
2 a particular person was buried within the cemetery?
3 A. That's correct. Except for the Smyllum area -- you will
4 come to that.
5 Q. We will come to that. Leaving that aside, generally
6 speaking, that was the position?
7 A. Yes.
8 Q. Then you mentioned the Smyllum children. What was the
9 position there in relation to being able to identify
10 where these children were buried?
11 A. The only indication of where they were buried was in the
12 section, which was the section set aside for Smyllum,
13 the Smyllum plot. There was no other indication.
14 Q. For example, there was no lair number that might have
15 identified a particular position?
16 A. No.
17 Q. So if we take someone like Samuel Carr, who I think we
18 understand was buried at Smyllum Cemetery -- and he was
19 on the register, wasn't he?
20 A. Yes.
21 Q. So it wouldn't be possible to identify the particular
22 plot where he has been buried?
23 A. No, it wouldn't.
24 Q. That applies to the children from Smyllum that were
25 buried in that area?

1 A. In that area, that's correct.
2 Q. I took you to the Sunday Post article a while ago,
3 Mrs Bishop, to note that post-1900, which was the period
4 you were particularly looking at, there would appear to
5 have been many, many children recorded as having died at
6 Smyllum. That appears to be what the article is saying;
7 is that your understanding?
8 A. That seems to be correct, yes.
9 Q. Insofar as the burial records are concerned, in contrast
10 to that, you found only records of 16 children?
11 A. That's correct.
12 Q. So, in relation to the other children, what can you tell
13 us or -- can you tell us anything about where they might
14 be buried?
15 A. The other children could be buried anywhere. In most
16 cases it is the family who would decide where a child
17 was buried, if there was family, if there were surviving
18 family. They would decide, so they could be buried
19 anywhere. There's no way of ever knowing where anyone
20 is buried. It is a process of digging around, I'm
21 afraid, to find where someone is buried.
22 Q. Of course, you can find out though in the St Mary's
23 Cemetery if a particular nun, for example, is buried in
24 a particular place because you can get the lair number
25 that will tell you where that nun is buried. So if you

1 have that information, you can work it out?
2 A. You can work it out, yes. But in general the other
3 children in the list, they could be buried anywhere
4 because it is everyone's right to decide where someone
5 is buried.
6 Q. Could they be buried at St Mary's Cemetery even though
7 they are not in the death or the burial register?
8 A. It is possible that they could be, but there's no
9 indication that that's the case. With every register
10 that's kept, there is a possibility that it is not
11 complete. That is a possibility. But --
12 Q. But in this particular register you could only find 16?
13 A. I only found 16 from the list I had, yes.
14 Q. I think you were asked to go back again to St Mary's to
15 carry out another inspection.
16 A. I was.
17 Q. Can I perhaps just focus briefly on that. If you could
18 turn to INQ.001.001.2775. I think you will find that at
19 tab 7 of your folder. What was the background to this
20 second visit?
21 A. When I was leaving after my first visit, I was having
22 a look round the church with Father Thomson and he
23 pointed out the existence of a book of remembrance.
24 I didn't realise it was a book of remembrance at the
25 time, but it was in glass case that was open in the

1 church. He just mentioned it, as I say, in passing and
2 he said that his predecessor had gone to Register House
3 and had managed to take all the -- a list of all the
4 deaths or a record of all the deaths at Smyllum and he
5 had compiled this book. So that was how I became aware
6 of this book. So I was asked to go back.
7 Q. Did you then look at the book to see to what extent you
8 could match names that you had found in the burial
9 registers to the book of remembrance?
10 A. I did.
11 Q. Is that what you set out in this particular part of your
12 research?
13 A. Well, I set out to find out exactly what this was and
14 how it related to what I had done. I was looking for
15 a relationship to what I had actually done before.
16 I was given the book again in the same room. It was
17 taken out of its case and I was given it and it did turn
18 out to be a book of remembrance, as in the page was
19 turned every day and all the burials carried out on
20 a particular date -- not a year, the date -- were put on
21 the same -- much as a book remembrance in a crematorium.
22 Q. I think your conclusion, following upon this visit,
23 which was on 23 November 2017, was that 11 of the 169
24 names that you identified on the burial register were in
25 the book of remembrance.

1 A. That's correct.
2 Q. So there was a discrepancy?
3 A. There was a discrepancy.
4 LADY SMITH: That's 11 of the 16?
5 A. Eleven of the 16, yes.
6 MR MacAULAY: Just some general points from what you saw in
7 the course of your research. In relation to the
8 reporting of the deaths, we have seen, for example, in
9 relation to Francis McColl, that the brother was the
10 informant. Did you see a pattern at all looking to the
11 death records you looked at as to who generally would be
12 reporting the deaths?
13 A. Generally, it was usually one of the Sisters and
14 I noted -- because I was doing this chronologically,
15 I noted that there were blocks of death registrations by
16 the same Sister, which maybe indicated that she was
17 given that duty of registering deaths, I assumed.
18 Something like that. But there obviously were family
19 members as well sometimes who informed on the deaths.
20 Obviously going through I was making my own conclusions.
21 That could have been if the child died, you know, in
22 hospital, maybe the family was there, but if the child
23 died in Smyllum, maybe it was a Sister. But there were
24 instances of family members registering the deaths but
25 I would say in the main it was one of the Sisters.

1 Q. The other point just to raise with you is that we know
2 that for any children buried at St Mary's Cemetery,
3 there doesn't appear to be a headstone in respect of
4 an individual child. Looking to your own experience as
5 a genealogist, what reasons might there be for there not
6 being a headstone to mark where an individual might be
7 buried?
8 A. Most graves don't have a headstone. It is a matter of
9 finance because it is down to the family to put up
10 a headstone.
11 Q. So it comes to cost?
12 A. It comes to cost and I mean in general, throughout the
13 years, probably about 25% to 30% of deaths have
14 a headstone and it is down to cost.
15 MR MacAULAY: Very well.
16 Thank you, Mrs Bishop. That's all I propose to ask
17 you. No written questions have been submitted, my Lady,
18 and I don't know if there are to be any questions.
19 LADY SMITH: Thank you very much. Can I check whether there
20 are any outstanding applications for questions?
21 Mrs Bishop, there are no more questions for you.
22 Thank you very much both for the report you did for us
23 in addition to the ones you did for the Sunday Post and
24 the BBC. It has been very helpful to have the
25 assistance of your detailed work. It sounds enormously

1 arduous and I'm now able to let you go. Thank you.
2 (The witness withdrew)
3 Mr MacAulay.
4 MR MacAULAY: My Lady, the next witness, Dr Turner, has been
5 programmed to come at 2 o'clock and he will be the last
6 witness today.
7 LADY SMITH: Thank you.
8 We will rise now and sit again at 2 o'clock to hear
9 from Dr Turner.
10 (12.30 pm)
11 (The luncheon adjournment)
12 (2.00 pm)
13 LADY SMITH: Mr MacAulay.
14 MR MacAULAY: Good afternoon, my Lady. The next witness is
15 Dr Thomas Liley Turner.
16 LADY SMITH: Thank you.
17 DR THOMAS LILEY TURNER (sworn)
18 LADY SMITH: Please sit down and make yourself comfortable.
19 A. Thank you.
20 LADY SMITH: Mr MacAulay.
21 Questions from MR MacAULAY
22 MR MacAULAY: My Lady.
23 Good afternoon, Dr Turner.
24 A. Good afternoon.
25 Q. Are you Thomas Liley Turner?

1 A. I am.
2 Q. And how old are you?
3 A. 74.
4 Q. Before I ask you questions about why you have come here
5 today, can I ask you to look at your CV and that's at
6 WIT.003.001.1295. I think you have a copy in the folder
7 in front of you and we also have it on the screen.
8 A. Okay.
9 Q. You set out your qualifications, your specialty being
10 medical paediatrics and neonatology. We can see from
11 your qualifications that you graduated in 1966 with
12 an MBCHB, that you are a fellow of the Royal College of
13 Physicians, both Glasgow and Edinburgh, and you are
14 a fellow of the Royal College of Physicians in Child
15 Health [sic]?
16 A. It is "Paediatrics and Child Health", but RCPCH.
17 Q. Under "Positions held", you tell us you were a full-time
18 consultant paediatrician from 1977 to 2007.
19 A. Correct, yes.
20 Q. Thereafter he held a locum post up until 2012.
21 A. Correct.
22 Q. Can you give us an understanding of what your experience
23 has been over the years, Dr Turner?
24 A. In my training I worked both in general medicine and in
25 paediatrics, although I worked almost entirely in

1 paediatrics from 1972 onwards as part of my training.
2 In my paediatric practice I was throughout engaged
3 in general paediatrics as well as neonatology, although
4 neonatology became my focus as my career developed.
5 I always did general paediatrics both in the wards
6 and for outpatients in the children's hospital in
7 Yorkhill. Then when I provisionally retired in 2007,
8 I worked for the next five years in general paediatrics,
9 working mostly in outpatient clinics in the Sick
10 Children's Hospital in Glasgow.
11 Q. Just looking to your current commitments, you tell us
12 that you are a part-time medical member of the Tribunals
13 Service and act in disability living allowance,
14 employment support and vaccine damage tribunals.
15 A. I did until I was 72, until two years ago, when I was
16 retired.
17 Q. That's compulsory is it?
18 A. Yes.
19 LADY SMITH: It sounds as though it wasn't something you
20 chose.
21 A. I would have preferred not to, yes.
22 MR MacAULAY: But you are, are you, a trustee of the
23 Scottish Cot Death Trust?
24 A. Yes.
25 Q. And chair of the Scientific Advisory Committee?

1 A. I am, yes.
2 Q. Is that something you have a particular interest in?
3 A. It is, yes.
4 Q. You are still involved in research; is that correct?
5 A. Well, research in relation to cot death.
6 Q. If we turn onto the next page of your CV, I think you
7 tell us under reference to "publications" that you still
8 are publishing.
9 A. Yes, and presenting at meetings.
10 Q. In addition, you have contributed extensively to
11 textbooks with 18 chapters so far in your career; is
12 that right?
13 A. That's correct, yes.
14 Q. You have been the author or co-author of three
15 individual textbooks.
16 A. Yes, these were textbooks on neonatology and one was for
17 students, undergraduate students.
18 Q. You provide us with some information about some
19 administrative management and advisory activities. For
20 example, are you still a senior examiner for the Royal
21 College of Paediatrics and Child Health?
22 A. I have been retired from that as well -- very recently.
23 Q. What about -- I think you were the Leonard Gow Lecturer
24 up until 2002.
25 A. Yes, that was a university appointment.

1 Q. You do tell us also that you continue to act as
2 an expert witness both for the pursuer and for the
3 defender, both sides.
4 A. That is correct, yes.
5 Q. Can I then look to see what you were asked to do for
6 this Inquiry, Dr Turner. If you could look to the
7 report that you prepared -- and I will put this on the
8 screen, it is INQ.001.001.2539.
9 To put this into context, I think, if you look at
10 the last page of the report on 2544, can we see that it
11 is dated 8 November 2017?
12 A. Correct, yes. I apologise that being the top of the
13 page. It is very wasteful.
14 Q. If we go back to 2539, the beginning of the report, in
15 the third paragraph you set out what you were asked to
16 do, what your remit was. Can you just elaborate upon
17 what your remit was?
18 A. It was to use my experience to look at the deaths only
19 as were provided by the Inquiry and to see if one
20 could -- if I could come to a conclusion about the
21 standards of care the children had received, whether
22 there were any obvious trends or patterns in the deaths,
23 particularly whether there was anything that seemed
24 inappropriate or unusual for the time, for the
25 historical time that I was looking at. And also if

1 there were other patterns that might have been gender
2 related or age related. It was just looking for --
3 I was asked:
4 "Did this look a fairly normal pattern of deaths or
5 were there things sticking out that were very odd?"
6 Q. In that exercise were you provided with a document that
7 listed quite a number of deaths associated with Smyllum?
8 A. Yes.
9 Q. If we could look please at INQ.001.001.2060. Is that
10 the document --
11 A. That's the document I saw, yes.
12 Q. As we look to the document, it begins -- the first date
13 we see is 1864, towards the top.
14 A. Yes.
15 Q. If we move on to page 2105, the last entry is for 1961;
16 is that right?
17 A. That is correct.
18 Q. Do we see the number 412 has been, as it were, allocated
19 to that particular entry?
20 A. Yes.
21 Q. But is that something of a misnomer because strictly, if
22 you were to add up the numbers, it doesn't come to that
23 number?
24 A. That's correct, yes. There is a big gap in 1908 where
25 the numbers jump quite surprisingly, with no

1 explanation.
2 Q. So if we perhaps just identify that and if we turn to
3 page 2080, towards the bottom of that page -- it is
4 2080.
5 A. We have 158 as the number --
6 Q. I will get it on the screen so we are all on the same
7 page. It is 2080?
8 A. 2080, yes.
9 Q. I'm looking at the screen behind you.
10 A. Sorry.
11 Q. What you are drawing attention to there is the entry at
12 the bottom of the page which is numbered 158 in 1908.
13 A. Yes.
14 Q. Then moving on to the next page, if we jump to
15 number 231, that's on page 2081, that is another example
16 of a hiccup in the numbers.
17 A. I think there were perhaps others but they were not as
18 obvious -- not as large a number as that.
19 Q. I think the author of the final report, I don't think
20 she accepts she numbered the deaths, but that's another
21 matter. In any event, you did add up the numbers and
22 you came to a particular number that you set out in your
23 report.
24 A. Yes.
25 Q. And the number you came to was 283.

1 A. I came to 283, yes.
2 Q. That was for the period 1864 to 1981.
3 A. To nineteen?
4 Q. In the period covered by the document that you were
5 provided with, which I think actually goes up to 1961.
6 A. 1961, yes.
7 Q. The information in that document included the year of
8 death, the name of the child, age of death, date of
9 death, location of the death and also information
10 regarding parents in certain instances.
11 A. Yes.
12 Q. For your purposes what then -- how did you approach your
13 task?
14 A. I needed to tabulate it so that I could understand it
15 myself because much of the information on this document
16 was not particularly helpful in a medical context. So
17 I decided that I would tabulate them under six headings:
18 the death number as on this document; the year of death;
19 the month of death, which would give me an idea if there
20 was a trend that was to do with seasonal; the age of the
21 child at death, which was provided in this document; the
22 gender of the child in case there was an obvious
23 male/female imbalance; and then the diagnosis.
24 The diagnosis that I took was a diagnosis given in
25 this document and I further decided that I would

1 subdivide the diagnoses into groups which is in the
2 report.
3 Q. In addition to the information in the document you have
4 just pointed to, were you also provided with a small
5 number of additional non-Lanark district death ledger
6 extracts?
7 A. Yes, there were three of them.
8 Q. We will look at these -- perhaps one of them in
9 a moment. You also tell us that following upon
10 a meeting that you had with the Inquiry team, you were
11 provided with another document that sought to identify
12 the length of time children had been in Smyllum prior to
13 death in a number of cases.
14 A. Yes.
15 Q. If I could look at that document. I don't know if it is
16 in your folder, but I will put it on the screen. It is
17 at INQ.001.001.3128.
18 I don't think it is in your folder, doctor, but if
19 you look at the screen in front of you you will see
20 that. Is that the document --
21 A. That's the document I was asked -- yes.
22 Q. Let's look at it for a moment or two. If we look at the
23 first entry, just to take that as an example, the
24 reference to a Mary Currie who appears to have been
25 admitted to Smyllum in 1920 and died 29 days later.

1 You were interested in the time frames, is that
2 correct, as to the how close the death was to the
3 admission to the home?
4 A. Yes.
5 Q. Marasmus; what is that?
6 A. That means poor weight gain, very thin, very --
7 a child -- another term would be "failure to thrive", a
8 child who was clearly poorly grown.
9 Q. If someone is admitted and shortly thereafter, in months
10 and weeks, dies, then you are looking to see whether or
11 not the reason for that might have been something that
12 had occurred prior to admission; is that the thinking?
13 A. Yes, it takes -- a considerable length of time to become
14 marasmic, if that is an accurate diagnosis. It
15 certainly doesn't occur within -- it would be unusual
16 within two to three months.
17 Q. So if you look at the next entry for Margaret Potts.
18 The date of birth is questionable but she was admitted
19 in September 1925 and died just over 3 months later,
20 again the same cause of death as marasmus. Again, you
21 looked at the date of entry to see whether or not it was
22 a condition that was there prior to her entry at
23 Smyllum?
24 A. I was using that as a surrogate for the information that
25 I didn't have, which was how long had you been in, what

1 condition were they in when they were admitted to
2 Smyllum.
3 Q. This is information that the Inquiry was able to obtain
4 from other records?
5 A. Yes.
6 Q. Then can I then, against that background, look to your
7 analysis, Dr Turner, where you deal with -- you begin
8 looking at this on page 2540 and you begin by telling
9 us, of course, that you found information on 283 deaths
10 and then you divide the deaths between different periods
11 of time.
12 A. Yes.
13 Q. In particular, you say that 79 deaths occurred in the
14 period 1920 onwards.
15 A. Yes.
16 Q. As a matter of arithmetic therefore, pre-1920, there
17 were 204 deaths.
18 A. Yes.
19 Q. Any particular reason for choosing 1920 as a dividing
20 line?
21 A. I was advised to do so by one of your colleagues.
22 Q. That's a good reason then!
23 A. Yes. "As instructed", I think would be --
24 Q. Let's then look at the pre-1920 deaths. Can you tell us
25 what you were able to work out from your analysis of

1 those deaths?
2 A. Well, there was no clear pattern as to the time in the
3 year when deaths occurred. I might have been concerned,
4 for example, had they all been occurring in the winter
5 time. That might have suggested there was a problem
6 with the environment in the winter in the orphanage.
7 There was no obvious pattern to the age of death.
8 There was a spectrum with some children dying at a very
9 early age and others dying in their early teens.
10 I think the oldest child was probably 14, I think, that
11 I remember in that age. There was no evidence of
12 a gender predominance in that group of children. So
13 I took that to indicate very generally that there was no
14 clear pattern that would allow me to make a conclusion
15 about care, about the quality of care.
16 Q. What about the actual causes of death?
17 A. The causes of death were much as I had expected to find.
18 The largest cause of death was tuberculosis.
19 Tuberculosis was identified by a number of -- under
20 a number of diagnostic labels. It wasn't just
21 tuberculosis, there was phthisis, which was the Greek
22 term for tuberculosis. It was all date related.
23 There was phthisis, there was tabes mesenterica,
24 which I had not seen before and I had to go and look
25 that one up. That was another tuberculosis or

1 tuberculosis-type disease. I think about more than 50%
2 of the cases were due to tuberculosis in that period.
3 Q. And I think it was quite well known that tuberculosis
4 was a killer.
5 A. It was widespread. In the whole community of all ages,
6 it was the cause of death in about 25/30% of the
7 population, particularly in the 1800s.
8 Q. And infectious?
9 A. Infectious diseases are also a huge -- it was highly
10 infectious, tuberculosis. There were two particular
11 types of tuberculosis that were occurring at that time.
12 There was what we understand as TB, the pulmonary type
13 of tuberculosis, but there was also tuberculosis due to
14 the what was called the bovine mycobacterium and that
15 was through infected milk. Until milk became
16 pasteurised, that was a less common but certainly a not
17 unusual cause of tuberculous death in children -- in
18 children in particular, I think, in the 1920s before
19 pasteurisation became commonplace.
20 There was also the common infectious diseases which
21 still are in our community to a much smaller extent
22 because of immunisation and herd immunity, but there
23 were lots of children -- there were little clusters of
24 children dying of pertussis, whooping cough. Again,
25 highly infectious and in a closed environment like

1 an orphanage, if you have one child with whooping cough,
2 it was quite likely that you would get more. The same
3 applied to measles.
4 There are other conditions called enteritis, which
5 again I assumed are either viral enteritis, which is
6 still common, and chest infections such as
7 bronchiolitis, which are still common. So there were
8 clusters of that.
9 Then there were a few odd cases which are the ones
10 that I was most interested in because I didn't quite
11 understand what the death certificate meant. These are
12 the ones that I particularly asked the Inquiry to try to
13 get some information on for me.
14 Q. Were these the ones we looked at on the list a moment
15 ago --
16 A. Yes.
17 Q. -- where the time between admission and death might have
18 been quite short?
19 A. That was some of them and there were others -- we have
20 to remember that most of these diagnoses or most of
21 these certificated causes of death were made by family
22 practitioners who were associated -- who were in the
23 locality. So they didn't have a huge amount of
24 opportunity to be sort of incisive in what they
25 diagnosed. The knowledge was much less then, but there

1 were one or two unusual ones like "teething", for
2 example, which took my breath away. Teething. So that
3 is surprising. There was others, sunstroke. It was
4 July when that child died, but sunstroke -- it seemed
5 unlikely that it was the case of death.
6 Then there were others that were a little more
7 specific, like nephritis, which was a kidney disease.
8 I was surprised that there was very little diagnosis
9 of congenital abnormality.
10 Q. It is a very small percentage.
11 A. Yes.
12 Q. 3.5%.
13 A. But in our current practice it would be a much more
14 substantial percentage. I was also surprised that there
15 were no cases that were said to be due to cerebral palsy
16 or birth trauma. None of these things seemed to be
17 represented. But then when I reflected, I thought most
18 of these children probably died very early in life and
19 would not be --
20 LADY SMITH: Would there also be an element of local doctors
21 who don't keep in touch with what's going on in the main
22 centres, getting out of date as to what a particular
23 congenital abnormality might be, in its signs and
24 symptoms, what birth trauma results in a child, and in
25 the habit of using the old diagnoses.

1 A. Yes, it was a catch-all sometimes. So the accuracy of
2 these diagnoses has to be quite debatable.
3 MR MacAULAY: But looking at the overall picture though,
4 looking at the percentages, 55% associated with TB in
5 one form or another, 35% some form of infection of
6 different types, 1.5% in fact in connection with
7 congenital abnormality. In relation to this period are
8 you able to --
9 A. I thought that was not unusual. I wasn't surprised by
10 that.
11 Q. That then brings us to the period from 1920 onwards.
12 You have identified 79 cases in this particular
13 category. Can you take us through that, your analysis
14 here?
15 A. Well, the first thing, as I said in my report, is that
16 there were years when no deaths were recorded at all and
17 that was really quite exceptional compared to the
18 previous cohort of cases.
19 Q. Does that reflect an improvement in the standard of
20 healthcare?
21 A. Yes. I thought that was in step with what was happening
22 in terms of healthcare in the community as a whole.
23 I would have been surprised had it not fallen steadily
24 and had there not been periods when there were no
25 deaths, given the size of the community.

1 Q. Then, if you look at the diagnoses that you identified,
2 what can you tell me about that?
3 A. Well, compared to the sort of 55% of children who died
4 with tuberculosis in the first cohort, from 1920 onwards
5 it dropped to 32% and the numbers dying of tuberculosis
6 fell rapidly over the first 10/20 years of that cohort,
7 the 1920 cohort onwards, which would be again in keeping
8 with what was happening in society as a whole.
9 Because the numbers are smaller, 44% who died with
10 a diagnosis of infection represents about not -- even
11 40 children, about 35 children. Again, there were
12 clearly clusters of infection causing deaths such as
13 flu, measles, and enteritis. There were no real
14 surprises in the types of infection that were ascribed
15 as the cause of death in that period.
16 Q. You also say that you thought that the quality of death
17 certification improved.
18 A. Yes, it was unusual then to get just the -- just
19 a general cause of death. It is hard to explain --
20 I think it is not difficult to explain, but what
21 happened was that as the years progressed, as the
22 decades progressed, it wasn't sufficient -- the
23 Registrar General no longer felt it was sufficient just
24 to give a single blanket cause of death, that medical
25 practitioners had to start taking causative death apart

1 and explaining them. So that was reflected in these
2 death certificates.
3 So many more certificates had more than one cause of
4 death. For example, it might say one died of seizures,
5 which would be correct, but then it would say the
6 seizures were due to epilepsy or the seizures were due
7 to cerebral tuberculosis. It became more logical. That
8 would be in keeping with the requirements to make death
9 certificates more specific.
10 Q. Has death certification historically had been a bit of
11 an issue as to exactly how accurate the certification
12 is?
13 A. I'm afraid so, yes.
14 Q. Although I think in recent times there has been
15 legislation that has tried to tighten that up.
16 A. I mean, before I retired, it took a considerable time to
17 write a death certificate, whereas I think in the 1920s
18 it would be a stroke of the pen. It is just different
19 times.
20 Q. Overall over that period then, was there anything that
21 stood out for you?
22 A. Well I think the 24% of them died of other conditions.
23 That I think reflects the fact that there were less of
24 them dying of TB and so other conditions became more
25 obvious or became a greater percentage of a smaller

1 total. We are still looking at 24% of 80 cases -- we
2 are talking a maximum of 20 cases. That's over a period
3 from 1920 to 1960, so it is a 40-year period. There are
4 also, I think later in the 1950s, quite long periods
5 when there were no deaths at all.
6 Q. If we move on then in your report, as you already
7 mentioned, you were asked to look at specific cases and
8 I think three in particular. I needn't trouble you with
9 two of those because we have already had some
10 consideration of those, but can I just ask you about one
11 particular case. I will put the death certificate on
12 the screen and it is INQ.001.001.2382. You deal with
13 this particular case on page 2542 just below halfway.
14 We are focusing on the bottom entry, 213 --
15 A. Yes.
16 Q. -- where we see reference to a Vincent McCorry, who died
17 on 17 May 1961. The usual residence is said to be
18 Smyllum Park Home in Lanark, although he died in
19 Strathclyde Hospital in Motherwell.
20 We note that he was aged 12 and that the cause of
21 death is "chronic cirrhosis of the liver".
22 A. Yes.
23 Q. Just on that, can you -- on the face of it, that might
24 look unusual, but it may not be unusual. What's your
25 view on that?

1 A. Cirrhosis of the liver means chronic -- a chronically
2 inflamed and damaged liver which has shrunken. We
3 adults think of it as a consequence of alcoholism,
4 I suppose that would be the first thing that you think
5 of. But in children that is never the case. It can --
6 damage to the liver can occur in a whole collection of
7 unusual relatively rare conditions, some of which are
8 inherited. Perhaps the most common inherited condition
9 which might have given you cirrhosis of the liver would
10 be cystic fibrosis. Now cystic fibrosis was not
11 recognised until the late 1950s, early 1960s. It was
12 not a condition that we understood.
13 So, what you would find -- what the doctor who
14 made -- who certified this condition probably was asked
15 to look at first was a child with a very swollen abdomen
16 and probably with jaundice. The swollen abdomen was due
17 to the collection of fluid in the abdomen and that's
18 called ascites. Faced with that, one has to try to
19 establish what might be the underlying cause of this.
20 So if it was an inherited condition, then cystic
21 fibrosis might be a likely candidate or a condition
22 called Wilson's disease which is another inherited
23 condition where you have progressive learning
24 difficulties, it affects families, and it leads to
25 general deterioration and the child dies with features

1 of ascites and a shrunken liver.
2 The liver -- assessing whether the liver was
3 shrunken or not was probably done by X-ray in the early
4 1960s. A lot of the technology we have now did not
5 exist then.
6 Chronic infections such as hepatitis were unusual at
7 that time. Unlike today where one might be thinking
8 about hepatitis B and C, these were relatively poorly
9 recognised, and the other conditions that might have
10 occurred in Scotland causing this would be some
11 condition where there was an abnormality of the blood
12 vessels in the abdomen supplying the liver and there
13 might be clots in these blood vessels and that would
14 cause ascites and fibrosis.
15 Q. Would you envisage that this condition would be
16 a gradual one --
17 A. Yes.
18 Q. -- rather than something with a sudden onset?
19 A. I think it would be gradual although it could be over
20 just a few months that it became apparent because one's
21 liver is able to cope with damage for some considerable
22 time before it presents as an illness and the first
23 presentation signs might well be the swelling of the
24 abdomen or the development of jaundice, but your liver
25 has to be in pretty poor shape before you get these

1 signs appearing.
2 So it is true that the condition would have been
3 present for some time. How much it would have been
4 obvious is difficult to assess because, unless you knew
5 that the child was at risk of this condition, because
6 you knew what the family history might be or the family
7 diagnosis might be, you are caught, you might say, with
8 a child who now has a swollen abdomen who was relatively
9 well a few weeks ago and then, gosh, what's the cause.
10 Q. In any event you do say that this consequence is
11 unlikely to be due to care deficiencies.
12 A. Yes. I couldn't conceive of a care deficiency --
13 a particular care deficiency which would lead to the
14 ultimate underlying diagnosis. There might have been
15 deficiencies in getting the child seen, getting the
16 child to hospital or -- sorry, getting the child seen by
17 the GP, but I can't comment on that. But I can't think
18 of a disorder that care would be a major part of that
19 would lead to this scenario.
20 LADY SMITH: In 1961, what treatment would have been given
21 to a child of 12 presenting with cirrhosis of the liver?
22 A. It would be medical treatment. It would be drugs -- and
23 there were precious few then. The fluid would have been
24 drained off the abdomen, but that would not have solved
25 the problem; it would simply have temporalised and been

1 symptomatic. In 1961 children with this condition died.
2 LADY SMITH: Necessarily or was it treatable?
3 A. I think necessarily. I mean in 1961 treating leukaemia
4 was extremely unusual and very short term. One could
5 get treatment for a few months with steroids with
6 leukaemia and you might get a bit better, but 95% of
7 children with that condition died, for example.
8 Children with cystic fibrosis, no chance of survival.
9 To live that long was quite unusual.
10 To have one of these inherited diseases -- I can't
11 think of what treatments were used in the early 1960s,
12 because I was a medical student then, which had either
13 a curative effect.
14 LADY SMITH: Back in 1961 we were before the days of
15 transplant surgery that can be so successful nowadays;
16 am I right?
17 A. Yes, we were at least 30 years before it.
18 MR MacAULAY: Moving on, Dr Turner. In the next section of
19 your report on page 2542, you have a heading "Additional
20 analysis". I think here you are looking at the
21 additional cases that you sought some further
22 information on.
23 A. Yes.
24 Q. So if we turn on to page 2543, you make the point that
25 following the information you were provided, it appears

1 that the majority of the infants had spent less than
2 six months in Smyllum.
3 A. Yes.
4 Q. That suggests that their condition may well have been
5 part of the reason for their admission.
6 A. One of the problems I had was I had no idea why the
7 children were in Smyllum. There was no information
8 available in the death certificate. Although one could
9 make -- you could conjecture that they were there
10 because in many cases both parents were deceased or one
11 parent was deceased, but that wasn't really sufficient
12 in my mind to say that was why they were there in
13 Smyllum Orphanage.
14 LADY SMITH: We have heard some accounts of maternal deaths
15 from TB but not every child from the ones we have heard
16 ending up in Smyllum were there because they had lost
17 a parent to TB and potentially, I suppose, themselves
18 had been exposed to it before going into the home.
19 A. Yes, congenital tuberculosis can occur and it did occur,
20 but seldom occurs now. But it was possible, looking at
21 the original document that I received, because it did
22 say on these documents -- under each child, it gave the
23 parent's name and whether they were alive or deceased
24 and it sometimes gave an occupation. So I could make
25 a -- it would be an assumption that they were there

1 because there were family pressures of various kinds or
2 no family.
3 MR MacAULAY: Can I then turn to the final section of your
4 report on page 2543 where it is headed "Comment", but
5 this effectively sets out your conclusions from the work
6 you have done. Can you perhaps take us through that,
7 Dr Turner?
8 A. I had to try to take into account my knowledge of the
9 history of what was happening in the community from 1861
10 onwards and some of that required me to do some reading,
11 some of it was something that was taught in medical
12 school and in general knowledge. So I knew that -- what
13 I could not do and what I did not have the ability to do
14 was to compare what was happening at Smyllum with any
15 other similar establishment in Scotland or elsewhere.
16 No one could provide me with that and I didn't expect
17 them to be able to do so, to be honest, but I therefore
18 had to compare or try to make a comparison between what
19 was happening at Smyllum and what was happening in the
20 community as a whole and there was some information
21 about death rates in the 1800s and early 1900s, but that
22 doesn't really relate to Smyllum itself because
23 Smyllum -- there were only children involved whereas the
24 death rates that are published are to do with the
25 population as a whole. So it was trying to compare

1 apples and pears, which was unfair both ways.
2 But, so it is an impression that I have rather than
3 actuality. My impression was that over the time the
4 number of deaths diminished as I suspect -- my
5 impression was they were occurring in society as
6 a whole.
7 I wasn't able to pick up any pattern in the age of
8 deaths. There was a spread of deaths and at all ages in
9 the month of death, in the gender. There was no pattern
10 there that could lead me to be concerned. For example,
11 there was nothing to suggest that boys were more or less
12 likely to die than girls or vice versa.
13 That suggested to me that it was likely -- again,
14 I didn't even know what the baseline was. I didn't know
15 how many boys or girls were admitted to Smyllum, but --
16 so I couldn't do a percentage, but from the records
17 I could see, there seemed to be no great difference and
18 so that suggested to me that the children were probably
19 treated equally, whatever that was. But they were
20 probably treated equally from the death perspective.
21 Q. Essentially, what you say, about halfway down that
22 paragraph, is that you cannot draw any conclusions from
23 the certified causes of death about the standard of care
24 the children had received other than to note that these
25 causes were in large part similar to those occurring in

1 the community at large?
2 A. That is correct.
3 Q. In particular tuberculosis and other infections?
4 A. Yes, the two main causes of death were the two main
5 causes of death in society at those times. I was --
6 I think I also went further and said that I was not
7 surprised that the communicable diseases such as measles
8 and whooping cough had a big effect on a closed
9 community, as it would have in any closed community.
10 Q. We heard in evidence, and may hear further evidence,
11 that at points in time there were well over a hundred
12 children in this orphanage. So that would be a factor
13 to take into account?
14 A. Yes. I don't know how they were housed, but if they
15 were housed as they might have been in a hospital
16 setting, the smaller children would be in one group, the
17 next age would be in the next group, et cetera, when
18 whooping cough came or measles came, it would rampage
19 through the under 5s or the under 2s very quickly
20 because they are such infectious diseases.
21 MR MacAULAY: Thank you, Dr Turner. That's all I propose to
22 ask you. Thank you for your assistance to this Inquiry.
23 My Lady, no written questions have been submitted
24 and I don't know if there are to be any questions.
25 LADY SMITH: Are there any outstanding applications for

1 questions of this witness? No. Thank you.
2 Dr Turner, there are no more questions for you.
3 Before I let you go, can I just thank you for the work
4 you have done for the Inquiry in looking at the
5 information we gave you and for producing your very
6 helpful report. Thank you.
7 A. Thank you.
8 (The witness withdrew)
9 LADY SMITH: Mr MacAulay.
10 MR MacAULAY: My Lady, can I then invite your Ladyship to
11 adjourn this phase of the Inquiry until 9 January.
12 LADY SMITH: When we will start at 10 o'clock in the
13 morning?
14 MR MacAULAY: Indeed, my Lady.
15 LADY SMITH: We are now going to adjourn until what will be
16 next year and we will resume hearing evidence at that
17 date. As I said earlier, that evidence will go on until
18 towards the end of January -- I think we are looking at
19 some time in the last week of January.
20 MR MacAULAY: Probably another three weeks or so.
21 LADY SMITH: Another three weeks or so.
22 Thank you all very much.
23 (2.50 pm)
24 (The Inquiry adjourned until 10..00am on Tuesday,
25 9 January 2017)

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