Scottish Child Abuse Inquiry

Witness Statement of

Graham MACKELLAR

Support person present: No

1. My name is Graham George MacKellar. My date of birth is **1965**. My contact details are known to the Inquiry.

Background

2. I am a Detective Inspector with Police Scotland. I have twenty eight years police service. At the time of the investigation into the circumstances surrounding Samuel Carr's death I worked for a department called Homicide Governance and Review. The department is located in Gartcosh, North Lanarkshire. Part of the role of our department was the review of unresolved homicides and suspicious deaths.

3. Our department was contacted by DC Jacqueline Anderson in around April 2015 regarding the investigation into the death of Samuel Carr. Samuel Carr died on 12 June 1964 when he was 6 years old while he was a resident at Smyllum in Lanark.

4. The investigation had previously been allocated to the Public Protection unit in Q Division. Q Division is the division which covers Lanarkshire. The investigation was to be transferred from Q Division to Homicide Governance and Review.

5. Homicide Governance and Review is not a big department. I can't remember how many of us were in the department. There were possibly about ten officers in the department. Officers in the department were working on numerous different investigations. The officers who worked on the Samuel Carr investigation were
primarily DS Desmond McKenna and DS Lyndsay Laird. They would allocate work out to other officers as and when other officers were available.

6. and were former residents of Smyllum. They had met each other in early 2015 at a meeting for survivors of abuse and they had discussed their time at Smyllum in Lanark. During their discussion they realised that they had both known another resident by the name of Samuel Carr. told that he had witnessed Samuel Carr being assaulted by a nun. He said that, several days after that, Samuel Carr had died. That discussion prompted to contact the National Confidential Forum (NCF).

7. provided information to the NCF. The NCF provide support to victims of abuse in relation to institutional care. The NCF send referrals to Police where persons disclose crimes and/or where there may be current risk.

8. said that he had been in Smyllum during the 1960s and had known a boy called Samuel Carr. He informed the NCF that Samuel Carr had died whilst he was a resident at Smyllum. He provided information that alleged that Samuel Carr had been assaulted by a nun in the orphanage and had died shortly thereafter.

9. In April 2015 after receiving information, the National Confidential Forum made a referral to Police Scotland's Child Abuse Unit. The National Confidential Forum informed the Child Abuse Unit that had come forward with information surrounding abuse at Smyllum and the death of Samuel Carr. The investigation was at that time allocated to DC Jacqueline Anderson. DC Anderson was from the Public Protection unit in Q Division.

Initial enquiries

10. DC Anderson had carried out some initial enquiries. She spoke with and provided her with a version of events where he witnessed
Samuel Carr being assaulted by a nun. He said that Samuel Carr had died sometime after that.

DC Anderson then made enquiries with the National Registers of Scotland in Edinburgh. She wanted to try and ascertain the cause of death of Samuel Carr. She spoke with Wilma Smith at the National Registers of Scotland who uncovered a copy of the entry for Samuel Carr's death in the Register of Deaths. This can be found at INQ.001.001.2381. The second entry, half way down the page, is the entry for Samuel Carr's death. It is dated 12 June 1964.

DC Anderson was informed by Wilma Smith that the stated primary cause of Samuel Carr's death was noted in the register as cerebral haemorrhage. Wilma Smith said that where the cause of death is given as cerebral haemorrhage there would normally be a second entry inserted in the register after the post-mortem which indicated the cause of death. In this case that hadn't been done. Wilma Smith in her experience would expect certain categories of death such as in the case of a child in care that the death would be investigated probably following a post mortem in order to ascertain the cause of death.

After DC Anderson completed her initial enquiries she contacted Homicide Governance and Review. She contacted us because she realised there was some doubt as to Samuel Carr's cause of death. She also realised that the case was more our remit. Part of the remit of HGR is to review and investigate any new intelligence or information regarding unresolved homicides provided by members of the public or from any other sources.

DC Anderson compiled a briefing paper in June 2015. This is a detailed summary of how she had been allocated the inquiry, her sources and the enquiries she had carried out. This briefing paper was made available to me at the time the investigation was transferred to our team. DC Anderson's briefing paper is dated 26 June 2015 and can be found at PSS.001.001.0292.
15. After DC Anderson contacted our team, an agreement was made between Q Division’s senior management and my senior management that there would be a review of the death of Samuel Carr. We wanted to ascertain if there was anything suspicious which would prompt a full investigation. It was also agreed that, should there be any separate instances of abuse uncovered, witnesses would be informed that their statements were going to be passed on to Q Division. We agreed that Q Division would undertake that side of the investigation.

Transfer from Q Division to Homicide Governance and Review

16. The investigation into the circumstances surrounding Samuel Carr’s death was called Operation Kern. All the documentation available was passed to us from Q Division alongside DC Anderson’s briefing paper. That included any statements that had already been taken.

17. I was appointed Senior Investigating Officer and DS Laird was appointed Family Liaison Officer. DC Laird met with Samuel Carr’s siblings at the outset to explain to the family that enquiries were being carried out.

18. As I have said, a statement had been taken from AAI. This is dated 9 June 2015 and found at PSS.001.001.0276 and PSS.001.001.0421 (duplicates).

19. AAI was a resident of Smyllum. I recall that some of his family members were also residents at Smyllum. He was a friend of Samuel Carr.

20. AAI recalled an incident where he was with Samuel Carr when they were around six years old. He recalled Samuel Carr having a piece of nylon and a match. Samuel Carr wanted to show him a lit match because AAI had never seen this before. AAI remembered Samuel Carr lighting the match and setting on fire the piece of nylon. He then said that Samuel Carr passed him the lit piece of nylon. AAI then burnt himself whilst holding the nylon. He said that he then
screamed and Sister came over to them. then recalled saying to Sister something along the lines of “Sammy burnt me.” then stated that he had witnessed Sister undertake a sustained assault on Samuel Carr using her fists and her feet. said that he had stopped the attack by jumping on Samuel Carr. He stated that prevented Sister from getting to Samuel Carr. stated that he believed that Sister was responsible for Samuel Carr’s death.

21. stated that he was taken by his own brother to the sick room to see Samuel Carr one or two days later. stated that he observed Samuel Carr urinating blood. He then stated that he recalled seeing ambulance personnel taking Samuel Carr away a couple of days later. could not be exact about timescales but he thought it was a day or two after the assault. He couldn’t identify exactly when the assault had occurred. No one else had witnessed the assault.

22. A statement was taken from on 26 May 2015 at Perth Police Office by a DC Andrew Walker. This can be found at CFS.001.001.0102.

23. A statement was taken from on 17 June 2015. This can be found at PSS.001.001.0216. In his statement states that he was at Smyllum but does not provide any information or knowledge regarding Samuel Carr or his death.


25. DI Craig Hosie at Q Division’s Public Protection Unit prepared a briefing paper for us. This was sent by DCI Paul Livingston at Q Division for DSU Bobby Hendren at Homicide Governance and Review. It set out the possible suspect nature of Samuel’s Carr’s death. It outlined how they came to be investigating Samuel Carr, what they had done and why they were passing the inquiry to Homicide Governance and Review.
The briefing paper essentially summarised where everybody was with the investigation. This briefing paper was made available to our senior management. It made them aware of the terms of our investigation. This briefing paper was dated 2 July 2015 and is at PSS.001.001.0265.

**Tracing the Post-Mortem Report**

27. From an early stage of the investigation, we were looking for a post-mortem report. We approached the Crown to see if they had any record of receiving the post-mortem report. It appeared the Crown Office did not hold a post-mortem report. PSS.001.001.0354 is an email exchange with Crown Office on this point.

**Other enquiries**

28. During the time when we were trying to trace the post-mortem report and other records, we also made enquiries with Samuel Carr’s family members and former residents who had been at Smyllum around the time of Samuel Carr’s death.

29. We re-contacted the National Registers of Scotland to try and identify why the deaths register was incomplete. A statement was taken from Wilma Smith on 29 July 2015. It is at PSS.001.001.0443. Wilma Smith was very knowledgeable. She told us that normally, in a case such as Samuel Carr’s, there would either be a second entry or an amendment which would be entered into the register once the post-mortem had been carried out. The registrar would be contacted so that this addition could be made. We were also able to establish with Wilma Smith that the post-mortem report was not held by the National Registers of Scotland.

30. After speaking to Wilma Smith we made further enquiries elsewhere. We contacted The Mitchell Library and we made enquiries regarding Social work records both with a negative result. We tried to locate the funeral directors that would likely have been involved around the time of Samuel Carr’s death. We also tried to contact a Dr Colin Bullough who had certified Samuel Carr’s death but discovered that he was deceased.
We made enquiries into locating Samuel Carr’s siblings. That was the beginning of us looking to speak with Samuel Carr’s surviving relatives.

A statement was taken from [redacted] of Samuel Carr. This is dated 27 July 2015 and can be found at PSS.001.001.0430. In the statement [redacted] was able to provide a history of the family and [redacted] recollections of [redacted] and his death.

[redacted] informed us that [redacted] had been told by the nuns at Smyllum that [redacted] had been taken to Yorkhill Hospital. That led us to look into the records formerly held by Yorkhill Hospital. We made enquiries with Yorkhill Hospital. That action can be found at PSS.001.001.0032.

When we contacted Yorkhill Hospital we were told that they no longer held Samuel Carr’s post-mortem report. We were told that a lot of records had been destroyed when the children’s hospital had been moved. I think their retention policy had been to only hold on to records for a period of ten years.

We took a statement from Anne Marie Carr, [redacted] sister of Samuel Carr. This is dated 30 July 2015 and is at PSS.001.001.0404. Anne Marie Carr was able to provide a list of family members, [redacted] of Samuel Carr. She was also able to provide a history of the family and her recollections of Samuel Carr and his death.

A statement was noted from Stewart Davidson who is employed as an Extract Services Officer at New Register House in Edinburgh. This can be found at PSS.001.001.0453. Mr Davidson provided extracts of Samuel Carr’s birth and death certificates held at Register House to the police, which were obtained to check if there was any further information held on them which could assist the investigation. They did not have anything further and therefore did not assist the investigation.
August 2015

37. On 4 August 2015, I provided a briefing paper for Assistant Chief Constable Malcolm Graham. This can be found at PSS.001.001.0448. This sets out where we were with the investigation at that early stage.

38. A statement was obtained from Francis Docherty dated on 5 August 2015 and found at PSS.001.001.0382. I think that Francis Docherty was involved with INCAS. He was also a former resident of Smyllum. He had been mentioned by other former residents so we decided to speak to him.

39. A statement was taken from [redacted] on 6 August 2015. This is at PSS.001.001.0369. She was an elderly woman. She provided a lot of historical data concerning the Carr family. She spoke of being told by [redacted] of Samuel Carr dying. She states that [redacted] told her that he had been told that Samuel Carr had been playing with a dead rat and that he hadn’t washed his hands. She stated that she had heard from [redacted] that the poison in the rat’s blood had then gone through Samuel Carr and that was what had caused his death. She didn’t know who had had reported that to [redacted]

40. A statement was taken from [redacted] ABK This is dated 10 August 2015 and is at PSS.001.001.0361. [redacted] ABK had been previously called [redacted] ABK. He was [redacted] JAA brother. [redacted] ABK had initially contacted the police regarding abuse that he had suffered during his time as a resident in Smyllum. I think he had initially made contact in 1999. He recalled Samuel Carr from his time at Smyllum. He talks of his discovery that Samuel Carr had died. He recalled being told by the staff or nuns that a rat had got him or that Samuel Carr had been poisoned by a rat.

Marjorie Turner

41. Marjorie Turner is a Consultant Forensic Pathologist at Glasgow University. Enquiries were made with her to try to identify if a post mortem took place.
42. In August 2015 I emailed Marjorie Turner to discuss the fact that it has been raised by some former resident of Smyllum that Samuel Carr had been playing with a rat and whether this may have contributed to his cause of death. She responded to say that at least some rat poison is warfarin which is also used as a drug to thin the blood and therefore can make an individual more susceptible to and/or exacerbate any haemorrhage. She said that cerebral haemorrhage alone as a cause of death could potentially reflect a natural cause (which she thought would be unusual in an otherwise healthy six year old) or trauma. The post mortem report was not available at that stage. An email exchange dated 11 August 2015 can be found at PSS.001.001.0220.

**Death Certificate**

43. We sought to obtain a copy of Samuel Carr’s death certificate. We did that to investigate who was the doctor who would have signed the death certificate. From recollection we were not able to obtain the individual death certificate. The death certificate either did not exist or we were unable to trace it. From recollection we discovered that there wouldn’t really be any more information on the death certificate than what appeared in the entry of the Register of Death. We obtained this information from Wilma Smith at the National Records of Scotland. She also provided helpful information about Yorkhill Hospital and registration districts in Glasgow. This was in an email dated 14 August 2015 which can be found at PSS.001.001.0245.

**Daughters of Charity Records**

44. A warrant was obtained to search the premises of the Daughters of Charity at Provincial House in London, where records relating to Smyllum Orphanage were held. All the records held by the Daughters of Charity were held in their offices down in London.

45. One of the reasons we wanted to obtain records from the Daughters of Charity was because we wanted to identify whether Sister [AGI] was still alive. We did manage to obtain her full details. Her full real name was [AGI]. We were able to confirm what her movements had been in terms of where she had worked. It was...
established that Sister had died in Wishaw General Hospital on 2014.

Earlier Statements

46. Statements recorded at earlier dates, including in connection with another investigation in England, were recovered. This was with a view to review what the various former residents of Smyllum had said and to see whether there were any other possible lines of enquiry. A statement of from 19 November 1998 was recovered. This can be found at PSS.001.001.0488. A statement of James Murray Miller, ex Assistant Director of Social Work at Greenock Social Work Department was recovered and is at PSS.001.001.0505. Three previous statements of were recovered. These are at PSS.001.001.0507, PSS.001.001.0511 and PSS.001.001.0512.

47. A copy was obtained of a statement given by at an earlier date, on 28 October 1999. This is at PSS.001.001.0391. He was also former resident of Smyllum. in his statement described the physical abuse he sustained while he was a resident there. In his statement recalled Samuel Carr coming to live at Smyllum and that he was assaulted by nuns regularly as he cried a lot. also recalled that Samuel died whilst at Smyllum and he understood that it was due to kidney failure.

November 2015

48. In November 2015 DS Laird prepared a report of the investigation to date and to identify further potential lines of inquiry. This is dated 3 November 2015 and can be found at PSS.001.001.0329.

December 2015

49. In December 2015 I was at a conference where Marjorie Turner was also attending. I mentioned to her that we had a problem locating Samuel Carr’s post-mortem report.
50. On 15 December 2015 Marjorie Turner contacted me via email. The email can be found at PSS.001.001.0513. In that email Marjorie Turner informed me that the paediatric department at Glasgow University had located the post-mortem report. It was located in the Department of Pathology and Laboratory Medicine at the Queen Elizabeth Hospital. It turned out that paediatric pathologists themselves retain post-mortem records. They held records that concern childhood mortalities. I understood that the paediatric pathologists retained the records for a period longer than the 10 years ordinarily adhered to by Yorkhill Hospital. The fact that the paediatric pathologists retained the documentation was helpful to the investigation.

The Post Mortem Report

51. The post mortem report can be found at PSS.001.001.0306. I am not from a medical background. I therefore found myself needing someone from a medical background to look at the report. I needed the report to be translated. Marjorie Turner assisted to put us in touch with Dr Dawn Penman and Dr Paul French, Consultant Paediatric and Perinatal Pathologists in the Department of Pathology and Laboratory Medicine at the Queen Elizabeth Hospital. There is an email from OS Laird to Dr Penman and Dr French dated 15 December 2015 at PSS.001.001.0525. They were asked to review the post mortem report and the histological sections taken during the post mortem examination. We arranged a meeting to speak with them.

Dr Penman and Dr French

52. On 24 February 2016 DS Lyndsay Laird and I met with Dr Dawn Penman and Dr Paul French at the Queen Elizabeth.

53. When we met Dr Penman and Dr French we discovered that they had slides that had been retained following Samuel Carr's post-mortem. They told us that it was their
opinion that Samuel Carr had died due to an infection in his brain. The slides essentially showed that, in layman's terms, there was mould on Samuel Carr's brain. We asked the pathologists what could have caused this. Our primary concern was whether the infection could have been as a result of Samuel Carr being assaulted. We asked them that. Dr Penman and Dr French told us categorically "no". They informed us that, from their review of the post-mortem report, there was no sign of any trauma or assault on the body. They stated that Samuel Carr was very small for his age. They speculated, from the information they had, that Samuel Carr's immune system was probably weak due to malnutrition. They concluded that it was an illness that had caused Samuel Carr's death and not an assault or any criminal act. We did mention the information we had received surrounding a rat possibly causing Samuel Carr's death. I don't think they made any mention of it in the report they later produced. From my recollection of the meeting, I don't think that they felt there was anything in the records they had to suggest that that played a part in his death.

Next Steps

54. The document at PSS.001.001.0222 is an email dated 4 March 2016 from me to DC Jacqueline Anderson briefly summarising where we were with the investigation at that point, having met with the pathologists.

55. Ultimately, Dr Penman and Dr French produced a report confirming what they had said to us at our meeting. It was their joint opinion that the cause of death of Samuel Carr was cerebral abscesses due to a fungal infection most likely, on the basis of morphology, an Aspergillus. Their considered view was that there was no evidence of any significant trauma to Samuel Carr. They view neglect as one possibility in a list of many potential causes for his vulnerability to the cerebral abscesses which in their opinion was the cause of death. The report is dated 14 June 2016 and is at PSS.001.001.0262.

56. The meeting and the follow up pathology report really drew a line under our investigation. We were investigating whether or not there was anything criminal in connection with Samuel Carr's death. The report from Dr Penman and Dr French
highlighted that their research of all the records held in respect of Samuel Carr's death that there was no evidence of significant trauma and that Sammy had died from cerebral aspergillus infection, therefore they found no evidence to suggest that there was any criminality involved in his death.

Timings

57. If we had traced the post-mortem report earlier it would have meant that we would have discovered the cause of death earlier. It would have become clearer, much earlier on, once we had spoken with the pathologists that the cause of death could not have been as a result of an assault.

58. If we hadn’t obtained the opinion from the pathologists we would have probably further proceeded to attempt to identify everybody who had been in Smyllum at the time of Samuel Carr’s death. That was an action we ultimately did not require to undertake.

AAI’s Statement

59. AAI’s account and statement was an important part of our investigation. There is no doubt that abuse went on at Smyllum. AAI’s account may well be very accurate. However, ultimately we could not establish a connection between the assault witnessed by AAI and the ultimate cause of death.

Final briefing paper

60. I put together a final briefing paper dated 9 August 2016. This can be found at CFS.001.001.0026. This was compiled for DCI James Smith who was my line manager. It was compiled following the receipt of the pathology report. The purpose of the briefing paper was to record a summary of the investigation and our findings. The briefing paper enabled DCI James Smith to brief the head of the department on our findings. It was then up to the head of the department to approve our findings that the cause of Samuel Carr’s death wasn’t suspicious.
Close of the investigation.

61. Following my submission of the final briefing paper I awaited approval from my management. Ultimately it was approved that no further enquiries were necessary. That was the end of us reviewing the death of Samuel Carr. The drafting of the final briefing paper was more or less my last involvement in the investigation. That paper became the closing document of the investigation.

62. Towards the end of investigation we spoke to Samuel Carr’s family to inform them of our findings. It was DS Laird who spoke to them. We asked the family whether they were happy for us to make aware of our findings. had phoned our department on a number of occasions wanting to know how the investigation was going. The family were happy for us to let know the outcome of the investigation. DS Laird spoke to and informed of the result of our investigation including the pathologists tracing and reviewing the PM report and the slides from the PM. There is an email from DS Laird at PSS.001.001.0311 about this.

63. Once our investigation was finalised we made everything we had available to Q Division. Q Division had access to all of our documents. We passed everything across. We did that because there were other incidents of abuse reported by some of the witnesses we had taken statements from during our enquiries. I have no knowledge of the further investigations made by Q division into any reports of abuse.

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

Signed

Dated 18.11.2017