

Scottish Child Abuse Inquiry

Witness Statement of

Carol McCaig

Support person present: No

1. My name is Carol McCaig. My date of birth is [REDACTED] 1963. My contact details are known to the Inquiry.

Qualifications / Training / Background

2. I started working in residential childcare in 1984 by nature of a temporary summer job in South Lanarkshire. In those days, my job title was houseparent. I became really interested in residential childcare and thought I was suited to it. Instead of moving on after the summer, I continued to work in South Lanarkshire. Within the first two years, I was promoted to senior houseparent. Then, South Lanarkshire Council seconded me to get a professional social work qualification. It was the old-fashioned social work qualification which was a certificate in social services and I did a childcare and management option. It is a full professional qualification, but one that doesn't exist anymore.
3. I worked in South Lanarkshire Council between 1984 and 1993. Almost immediately after I did my professional training, I got a unit managers job and worked across various units in South Lanarkshire. In 1993, there were some differing views about how the structure of children's units should be run. There was a restructure and the first batch of real external management was introduced.

4. Glasgow Council were also developing their units quite rapidly at that time and were running more specialised types of units. I went to Glasgow, when it was still the Glasgow districts, to work as a unit manager with a unit that concentrated on short term residential work. Instead of just getting children into care and working with them in a residential establishment, the idea of that unit was to get them in, but to keep working with their families to get them home quickly. By this point in my career, I was already very much of the opinion that long term residential care wasn't right and extensive efforts had to be made to get children back to their families. That's why I was very interested in doing short term work.
5. I worked in Northwest Glasgow for a couple of years. It was a very rigorous job. Then, I was asked to go to another children's unit in Glasgow who had received a bad inspection report. The district manager in Glasgow was unaccepting of a unit not doing well. I was dispatched to attend to that. I did that for a year, and the unit was reinspected and found to be shipshape. In the meantime, that region had been disaggregated. The person who had been the district manager in Northwest Glasgow, Sheena Duncan, was then the director in Renfrewshire. With some encouragement from her, I applied for the centre manager post at Newfield in 1996, which I successfully got.
6. I worked in Renfrewshire for six years. I was working as the centre manager at Newfield, which was a considerably bigger job than unit manager. During that period, I also did some external management to cover a long-term absence and I was seconded to carry out an investigation into Gryffe, a large children's home in the area, which had a catalogue of complaints and mismanagement. I was out of Newfield for two significant periods.
7. In 2002, I stopped working in residential childcare. I went to work in external management at, what was now, Glasgow City Council. It was in that role, that I had my main involvement with Kerelaw Residential School. Through the Kerelaw investigation, which took me to around 2005, I was firmly of the opinion that I didn't want to work in residential childcare anymore, in any capacity. That just couldn't be my career anymore.

8. At that point in time, Glasgow City Council offered me a newly developed post called Practice Audit. The post centred around professional governance of social work practice. I looked at how well the council was meeting their practice and statutory requirements in relation to a wide range of topics such as, childcare, adult care, mental health and criminal justice. I was also involved in the development of investigation skills to look at areas of practice and produce detailed reports for social work governance and then later, for the health and social care partnership governance. I would prepare a report on how the area of work was being performed, highlight areas that required development, and make recommendations. These would be implemented, and I would monitor it. I found it an interesting and absorbing job and I was in that role until I retired in 2020.
9. I have already provided a statement to the Inquiry regarding other matters. I have not gained any further qualifications since then.

Investigation into Gryffe Castle Children's Home

10. In 1998, whilst I was Centre Manager at Newfield, I was asked to carry out an investigation into Gryffe, a large children's home in the area, which had a catalogue of complaints and mismanagement.
11. This request came from Joan Lafferty who was the Principal Officer (Child Care) at Renfrewshire Council.
12. During an initial chat about it, Joan informed me that an initial fact-finding investigation had been carried out following a complaint from a resident of Gryffe. This had raised a number of questions and concerns and they now wanted me to carry out a full and comprehensive internal investigation.
13. I was told there were complaints outstanding that needed to be looked into. I was to establish whether the young people knew how to use the complaints system. I was

informed that there was a lot of violence between the young people and that there had been a peak in absconding.

14. I agreed to conduct the investigation. Joan said she would supply a note taker from Social Work HQ and she asked me to give her an indicator of what else I would need to support my investigation.
15. I then got written instruction about what she wanted me to do. This instruction detailed some of the following issues that I was to investigate: the complaints system in the unit, recording and logging practice, supervision and recording, crisis support to staff, practice encouraging school attendance, practice surrounding young people who may abscond, practice surrounding safe care and supervision of children.
16. I was allocated was Janie Fraser to assist with the investigation.
17. It was obvious from an early stage that there were going to be disciplinary hearings for a number of staff. I borrowed some resources from Newfield to help me run Gryffe.
18. After the initial investigation, Paul Crieghton who was the Unit Manager at Gryffe had been put on a precautionary suspension, as had a ^{RHQ} [REDACTED] who was a middle manager.

My investigation at Gryffe

19. Gryffe was a big old building and it was unwelcoming. If you were a young person arriving there in the middle of the night it must have been absolutely terrifying.
20. When I arrived at Gryffe to conduct the investigation the was structure and processes currently in place were in disarray and there was a lack of capable senior staff.
21. The manager, Paul Crieghton, was on the precautionary suspension. Diane Ralph, his deputy, was off sick because she was under so much pressure. She took a lot of

responsibility for administrating the unit due to Paul Crieghton's inactivity. She and Margaret McLaughlin were both off sick and they were both individuals who were relied upon heavily.

22. The two of them, who were heavily relied upon, going off sick, probably brought things to head. Even when Diane Ralph was off sick, she was still coming in and doing the cash imprest because Paul Crieghton wouldn't do it.
23. As a result, not only was I investigating the complaints and potential issues I had been tasked with, but I ended up managing the place for the three months I was there so I did negotiate to borrow some management resource from Newfield.
24. I was trying to run the place and conduct investigations and that was very challenging. Everything was run down in terms of the routine. In addition the upkeep of the old building was problematic.
25. There wasn't a leading light amongst the staff. Paul Crieghton had been at Gryffe for a long time. I became a unit manager in either 1989 or 1990 and I know he was a unit manager in 1990. In the documents I was sent by the Inquiry, I saw a reference to him being in Carsewood Children's Home. He must have moved about or he maybe went and managed Carsewood for a while, so he wasn't there continuously, but I am sure he had been there for a long time.
26. Supervision was completely dead and the management thought they had an office job. There was also 'on the floor' senior members of staff who just stayed in their office as well. There were layers of people in their offices instead of getting out and working with the children.
27. Before I went there it had been a very big unit, but they were beginning to reduce their numbers due to restructuring. I think they had either opened or expanded somewhere else and Gryffe had been reduced, then further reduced. I think they were looking for another two houses to replace Gryffe and that was part of the problem with motivation. It was one of these places that was run for the benefit of the staff. I think the staff were

institutionalised to the big unit, big team, grounds and house. It was as if they were just letting things happen because they felt that Gryffe was being taken off of them, so they didn't care about doing their jobs effectively.

28. I was doing things immediately when I arrived at Gryffe to make improvements as the problems were there in my face and had to be addressed. I initially concentrated on improvements more than the investigation.
29. In order to get structures back in place, I spoke to every member of staff and spent time on shift with every single one of them.
30. It was obvious on my arrival that there was a big boy who had recently left Gryffe who had been the 'top boy'. He had basically had the run of the place and whatever he said went. I never met this boy and don't remember his name, but it appeared that he and the other big boys were being used by the staff to keep order in the place. There was a lot of peer pressure going on and there was an ongoing battle amongst the boys to see who was going to replace him as 'top boy'.
31. This hierarchical business was a big feature of Gryffe. The idea that someone was 'top dog' and others were bottom of the heap, was a real issue for the kids. It tends to happen naturally in care establishments, to an extent, but in this case, it was set up in such a way that it helped the staff. That however was difficult to prove.
32. There was 'favourites' status which was very much aligned with hierarchy amongst the young people. If you kept things nice and easy for staff by keeping the younger kids in order and keeping the girls in order, you would likely become a 'favourite'. The favourites were all boys, so it was very gender specific too. It was a case of if you kept everything nice and easy for the staff then everything flowed your way as a favourite.
33. There were other kids who were favourites but that was maybe because they had been there a long time and didn't cause trouble. It was very much a them and us with the new kids who came in, against the older kids.

34. The state of the building was another issue because by that time, it was really unsuitable for purpose. It was a great big house, it was difficult to arrange it and kids might have to share bedrooms. There was one bedroom that was shared by three and when you have all this hierarchical business going on with the kids, that was a problem.
35. As part of my investigation, I was asked to look at the money. I don't know why, but Joan specified that I was to do a full imprest, which I did, and the money was not right. I don't think it was because anybody was stealing the money. It was because it wasn't being spent in the way that I would have expected it to be spent.
36. For example, recreational allowance, which is your biggest tool because you need it to do activities with the young people in order to build relationships with them, wasn't being spent in the way it should. Instead of organising activities, staff would actually give some of the kids their share of the recreation money to spend themselves. I was shocked as I had never seen that in my life. It was basically a bribe so the ones that were behaving would get recreational money.
37. From my investigation other children told me there had been problems with "top boys." They'd get their pocket money, and they'd get recreational money. That wasn't right and that tied into staff having kids that kept order for them. Staff wanted to get certain 'big boys' on side. Staff didn't really have any compunction about the 'top boy' or big boys going to batter somebody else. They were lacking in any kind of fear about letting loose that kind of peer pressure and it had certainly gone very, very wrong with the big boy they had before.
38. There was also a question mark about whether the 'top boy' who had left had been frequenting staff members homes. That was never really bottomed out but I was always a bit suspicious about it. I never really got any evidence though as he denied it and the staff denied it. Other kids did say it happened and I would be inclined to think it did. He had denied this to staff previously prior to my investigation. I also had his through care worker sound him out about it whilst I was investigating but he still denied it.

39. The staff were lazy. This business about giving the children their recreation and clothing money in their hands was just to save them having to do the work. The managers were in their office, the staff were in their office, and the kids had this huge building where they were roaming about, vandalising it and fighting with each other.
40. I found the home to be quite dysfunctional. The main issues were that the staff were very slow, very lazy, not care planning and not keeping paperwork up to date. They were not engaging with the kids properly, except for the occasional ones that had a good relationship with their key worker that they had maybe had for a long time. They weren't taking kids on outings or arranging activities which is always a bug bare of mine and what my expectation of that was, was an absolute shock to them.
41. I told them I wanted a written programme and if there was any default, I wanted to know the specific reason why. I wanted to see them persuading kids that they were going ice skating or on whatever activity it was.
42. At first, when we told the kids we were going to be doing these activities, their response was one of disappointment and saying "Aw, we're used to just doing our own thing." We told them they could still do their own thing as long as they were actually doing something, like a hobby or going to see a friend, but if they intended to just hang around causing problems for each other, then they would not be doing their own thing. That was a culture shock for the children and the staff.
43. When I went to Gryffe, there were only two out of fourteen kids going to school as staff had stopped trying to get them to go to school. Most of the kids were older, secondary school age from about fourteen years to sixteen years.
44. The staff were not fulfilling their professional duties towards the kids. They were not facilitating proper care reviews or updating care plans and there was no drive to work towards returning children to their families.
45. During the first two months that I was there, we managed to get three or four kids home because I was proactive and got the parents involved. I sent the keyworkers out

to meet with the families, despite the keyworkers being resistant as they didn't believe it was their job.

46. I was asking the staff quite openly why the records were a complete shambles. They said everything had gone downhill because the kids had been so difficult. All of this was absolute rubbish because they weren't working with the kids either.
47. If they had been really working with them, and they were really difficult kids, I would have been quite sympathetic to a slippage in the paperwork, but it wasn't really like that.
48. Paul Crieghton was extremely poorly motivated. He just used to strum his guitar whilst 'Rome burned' basically. He wouldn't tell anybody anything, he wouldn't tell a member of staff to buck their ideas up, if staff were trying to get through to a child about their behaviour, he would undermine them and would cut the legs away from them. He was actually a clever guy, but he was just really lazy. Diane Ralph did everything in terms of administration.
49. I knew who Paul Crieghton was before I went to Gryffe because I had met him at Strathclyde Regional Council meetings. I recall one in particular, I believe it was a standing meeting for officers in charge where he held forth like nobody's business because he ran one of the biggest units.
50. He had also applied for the job that I got at Newfield and was exceptionally rude to me when I got that job. He clearly thought he was the man for the job and couldn't believe they had given it to me.
51. During my investigation, I made a number of findings against Paul Crieghton. He was not acting in accordance with what was expected of a unit manager. In particular, I found that he wasn't doing any record sampling, he didn't know the care plans and they weren't up to date. He wasn't setting proper parameters for care and control, he was allowing excessive sanctions, he wasn't debriefing staff after violent incidents and he hadn't ensured proper staff training.

52. He ended up subject to disciplinary action but I don't remember how much my findings were featured because I didn't look through all the detail of that. There was nothing to suggest he was being verbally, mentally or physically abusive towards children in his care, he simply wasn't doing his job as a unit manager.
53. There were also questions raised about Liz Edwards, who was Gryffe's external manager and Paul Crieghton's line manager. She had been the external manager and had been for far too long. I have managed external managers, and they dislike it when you rotate them around the units. I did this frequently because it is not a job where you are to be pally with somebody as you are there to scrutinise. It is actually better if they are not in a long-term position as external manager for one place.
54. Liz and Paul both lived locally and seemed to be on very friendly terms. She wasn't managing him very well. It was really interesting because I went on to work with Liz later on. She had taken the criticism, following my investigation, to heart and had really pulled her socks up. I think she realised she could have been disciplined. She wasn't as bad as Paul. She used to talk to the kids all the time and was a little bit concerned about what was happening in Gryffe.
55. The staff hadn't been properly trained in TCI (Therapeutic Crisis Intervention). I didn't get the feeling that they were going out of their way to restrain people, it was more a feeling that they weren't managing the kids well, so they were getting into difficult situations.
56. None of that became a disciplinary matter because they hadn't been properly trained. There had been a shortfall in that. I think Paul Crieghton was a TCI trainer or certainly a refresher trainer and he hadn't refreshed any of his own staff's training. None of that was done properly, nor was it recorded properly.
57. During my investigation kids weren't really complaining about restraint because they just thought it was staff breaking up fights. I never became aware of any restraint related injuries.

58. The staff weren't a team, they weren't loyal and they were all reporting on and blaming each other. There was a small pool of people that worked there and some of them were related. That all had a bearing on how they weren't a proper team.
59. There was a number of female staff that were quite unlikeable. There was woman called HGF and she just narked and nagged at the kids all the time. RHQ narked at the kids all the time. Another woman called Veronica also narked at them, so there was a style amongst the female members of staff, and some male members of staff were very lazy.
60. None of these women were nice people but what they were doing probably fell short of being abusive. I was only there for three months, but particularly HGF, I witnessed being very sharp tongued, very sharp in the tone she used when speaking to the kids and never smiled at them. I got her supervisor to speak to her twice about the way she spoke to them. I asked her supervisor to tell her she needed to think about how she could soften that up and the impact that she was having on relationships with them due to the way she spoke. HGF, Veronica and RHQ were all inflammatory and could create trouble between the kids.
61. HGF was a day shift residential worker. I did have concerns about the way she interacted with the girls. HGF was argumentative with the kids and would never let anything go. When you are working with kids you need to choose your battles, but she wasn't like that. She was picky and would go on about things with them. She was over the top picky and sometimes needlessly so. She didn't have a nice manner with them either and she could be quite shrill. She didn't give the impression she was there because she liked the young people, because I don't think she did.
62. I had to speak to her line manager on more than occasion about her as I wanted to ensure her manager was aware that she was contributing to lots of small incidents involving the young people, such as kids storming off and slamming doors. Quite often she was the originator of the problem because of the way she was dealing with them or speaking to them, and it was usually her tone or demeanour that set them off.

63. I asked HGF's line manager to explore those very things with her to ascertain if she was aware that was how she acted. I believe he was scared to raise these concerns with her. I think the kids were too and didn't want to be at the sharp end of her tongue.
64. The other thing was that she would often get into a verbal scrap with other members of staff. It would be over silly little things like contradicting what another member of staff had said or criticising their actions.
65. She never faced disciplinary proceedings as I would say her behaviour didn't reach that threshold. That said, if I had supervised her over a long period of time, as her manager, I would have expected an improvement in her demeanour because it wasn't good.
66. I would also say that HGF was overly punitive over small things. She would point out to a child that they weren't wearing their slippers and so that meant they weren't getting their pocket money. She was on the kids constantly, nipping away at them but not dealing with the big things.
67. I believe HGF is now dead.
68. I had concerns about RHQ. She came across as uncaring and would say things like the kids weren't very nice and if we had better kids, things wouldn't be as bad. She would keep punishments with kids going for ages. She was overly punitive and would frequently sanction kids by not giving out pocket money or recreation money.
69. RHQ was also involved in incidents of abuse and neglect that I recommended she should be disciplined for.
70. RHT was another one that faced disciplinary proceedings on my recommendations. He was responsible for a couple of adverse comments to kids. He was similar to HGF in that it was generally low-level things but he was also

overly punitive as well. He would stop a child's pocket money or refuse to allow a child to go on an outing over something minor.

71. He was not popular with the kids because of the way he treated them. [REDACTED] just wasn't good at engaging with kids. That said, when he had a better manager and he was feeling better about things, he did definitely improve. He wasn't lazy and he would find work for himself. I would also say he was quite good at getting the kids involved in practical things like getting them to help wash the van. He also responded well to getting good feedback about those things he had demonstrated and been good at. This behaviour all happened after he had been disciplined. I would go so far as to say he reinvented himself after the disciplinary matters.

Abusive incidents and ill treatment of children at Gryffe

72. The complaints that I looked at and other incidents that came to light during my investigation that I consider constituted ill treatment of the children at Gryffe appeared in my report. My recommendations for the disciplinary hearings are detailed in my report.

Abuse of hearing-impaired pupil - [REDACTED]

73. There was a boy in Gryffe called [REDACTED] who had damaged ears and was hearing impaired. I knew him as he had previously been in Newfield Assessment Centre. A complaint had been made against [REDACTED] RHQ that she had deliberately banged pot lids together right next to his ears. She had also been accused of holding a transistor radio against his ear and playing it loudly. Both these incidents had caused [REDACTED] to become gravely distressed.
74. When [REDACTED] realised I was concluding my investigation at Gryffe to go back to Newfield, he pleaded with me to transfer him back there and to try and get him home to his mum. Ultimately, we did manage to get him back to Newfield. The 'narkiness' in Gryffe must

have been really bad for him because every time I saw him, he would thank me for bringing him back because he absolutely hated it at Gryffe.

Pulling covers off of children whilst in their beds

75. Complaints had been about various members of staff including RHQ [REDACTED] that they were pulling the bedcovers back off children in the mornings as a way of waking them up and getting them out of bed.

Theft of laptop – false allegation against [REDACTED]

76. A boy called [REDACTED] was falsely and publicly accused by staff of stealing a laptop. I know that it is not abuse in the form of physical abuse, but that boy was so upset. He said the reason staff had accused him of stealing the laptop was because he was a thief before going to Gryffe. There was no real reason other than he had been known to steal something before. He told me that just because he was a thief, it didn't mean he was the one who stole the laptop. He admitted he had stolen before but swore he hadn't stolen the laptop.
77. [REDACTED] was most upset by staff accusing him publicly, in front of other kids, and because they contacted his family who he was trying to build bridges with. [REDACTED] was a kid who went on home leave, so Gryffe staff went to his home, told his family as fact that he had stolen the laptop and searched his bedroom at his family home. The police weren't involved in the incident and it was later discovered that he hadn't actually stolen the laptop but he never got an apology.

Isolation of children

78. During my investigation, several kids mentioned a room they would be taken to in order to calm down. If a kid was acting out in a big group of kids, they would be taken to this room. These kids said they didn't like it and that it was cold. There was a room at Gryffe that the staff used as, what I would call, a quiet room. Lots of children's homes

had something of this nature but I wanted to establish how it was being used at Gryffe. That proved a bit difficult because the kids were saying different things about it.

79. Removing a kid who is acting out from a group situation and putting them in a quiet room to calm down wasn't necessarily forbidden, but it's how it's done that can cause problems. You need to look at how you move a kid who is acting out to the quiet room and whether the kid was locked in. The quiet room at Gryffe didn't lock, so that wasn't an issue. There was however a potential issue, as there always is, in getting an already disgruntled kid to move willingly to the quiet room without staff having to physically move a child which could inflame the situation. I instructed them to stop using the quiet room at all.
80. The only other issues of physical abuse that I became aware of were incidents of children hitting other children at the behest of the staff.

Staff member threatening to spit in child's water

81. There was an allegation reported to me that RHT had said to another member of staff that he was going to spit in a young person's water jug. That incident was reported to me by a night shift female worker.
82. RHT must have been on an overtime shift this particular night and the female member of staff had been asked by a young person for a jug of water. That member of staff, like many, was of the opinion that once a child was in bed the last thing you wanted was the youngster getting up out of their bed and wandering about. For this reason, and because she had been asked for it by a youngster, she then asked RHT to get it for her. He had allegedly responded by saying he wasn't that young person's slave and that she, the young person, should have got it before she went to bed.
83. The night shift worker managed to convince him to get it, but RHT had joked to another member of staff, RIU, in the presence of the female night shift worker, that he was going to get it, but he was going to spit in it. The female night worker was disgusted by this and informed me about it.

84. As far as I know he never followed through with his threat and said it as, what he considered to be, a joke. It was inappropriate, nonetheless. I made enquiries with **RIU** and following a few questions he backed up what the female night shift worker had reported.
85. **RHT** would have had a disciplinary interview during the inquiries. Given what his two colleagues had said, I imagine he would have subsequently admitted it, but I do not recall the interview.

Peer Sexual Abuse

86. This is probably the most serious thing and maybe the least conclusive. There were teenage girls, one of whom alleged that one of the "top boys" had been sexually abusive to her and her friend and that particular boy was gone. She was still quite traumatised by that, and she could see the whole thing repeating itself with them getting a new 'top boy'.
87. They were older kids and if I had been managing that place longer, sexual behaviour between the boys and the girls would have been something I would have looked at. It was a difficult building to supervise as there were lots of nooks and crannies, plenty of places for privacy. I would have been very worried about anything like that and any kind of duress related to that, given they were so hierarchical.
88. There were also some allegations from some of the young women that some of the boys had been sexually inappropriate towards them and the staff were not on that at all.

Child Sexual Exploitation / Grooming

89. There was another issue involving the girls that we never really got to the bottom of. The police were involved and the harmful behaviour was all definitely stopped but we never got a full story.

90. The staff were not really appealing as people that the kids would really like. They weren't warm, caring, nice or lovely, but the cooks and the cleaners were. The cooks were very caring towards the children, were used to having long term kids and had adapted to the kids coming and going better than the staff had. They would have the kids in to cook with them and would chat to them. I've always thought it best to get onside with the cooks and the cleaners as they know everything and that is what I did. They were telling me that some of the girls were going out, in their words, 'dressed like hookers'.
91. At the same time I was perusing all the financial records, I saw that the older girls were getting their clothing money and their recreation money in their hand and being allowed to go out and spend this money on their own. I am calling them older girls, but that is because they were older girls in the context of the home, but they were only fifteen years old, maybe sixteen, but they were young.
92. They were buying clothes that were suitable for, putting it as nicely as I can put it, 'going out on the street.' These were not clothes that I would let a teenager girl in my care buy.
93. It was daft to let the girls go shopping on their own. Shopping was a big thing for the kids, so my practice, at my unit, was that I would always get their key worker to go with them, turn it into them getting a lunch as well and making it fun. The staff at Gryffe weren't doing that, they were just really lazy. They just gave them their money in their hand and these girls would come back with these inappropriate clothes.
94. One item of clothing bought had been recorded as a 'Baby Doll' outfit, so one girl was going out dressed in something that you might wear to your bed on your honeymoon, a wee tiny pair of pants and a tiny dress that just came to the top of her thighs so you could hardly even call it a dress. She was allowed to buy that with council provided clothing money and they had been letting her go out dressed like that.
95. There was a missing link with the staff because I was questioning why they hadn't been seeing what she was buying when she was bringing back the receipts to them. I

was asking them why they thought that was okay for her to go out dressed like that and they would say "Oh, but she had her coat on, on top of it." It was a lack of care.

96. I found out that at least two of these girls were then wearing these clothes to go and do some sort of work for the local takeaway shop in Bridge of Weir. They were then coming back in cars late at night, sometimes not until the next morning.
97. I can't remember the girls' names, but they weren't getting set shifts of definite nights a week, and it turned out that they weren't actually doing any work serving food or any other jobs in the takeaway.
98. We found this out when they were missing because we went there as our first port of call to see if they were there. They had maybe started off at the shop, but they weren't there in the middle of the evening when we went to look for them.
99. It was a mixed problem because the same two girls were also getting on a bus and going into Glasgow, which might or might not have been related to the local situation at the shop. We knew they had been going there because they had been brought back from there by the police after absconding.
100. When the girls were returning to the unit after they were meant to have been working at the takeaway, they were late or sometimes didn't return until the next morning. They would sometimes return with cigarettes or cash. The girls would boast about it, and the others would tell on them, so the staff would end up finding out about it.
101. There was every indicator that there was possible sexual exploitation of these girls. The way they were going out dressed, them disappearing for evenings or overnight and them having unaccounted for amounts of money, all made me believe these girls were being taken advantage of.
102. To my mind Paul Crieghton should have identified these issues and put an end to them. These girls were vulnerable. One of them had certainly been quite a long-

standing victim of abuse in her family and was very vulnerable and the other one looked like she was involved in that as well.

103. The third girl involved was in all sorts of trouble. She had seen a murder in Ferguslie Park, Paisley. I'm not sure whether this was before or once she was at Gryffe. She was going to get killed, because she had seen this murder and was talking about it. She may also have been previously involved in sexual exploitation. There were all sorts of things going on for her. She actually went into secure care for about three months as a moral safeguarding type of thing. I would not usually be in favour of that but in these particular circumstances, it was probably a lifesaver because she was saying all the wrong things about all the wrong people.
104. Although I couldn't prove anything, to me, all the evidence indicated that the child sexual exploitation was going on when I got there, I put a stop to this by insisting structured activities were put in place all the time. The staff had to get their lazy selves out of the office, get structured activities put in place and make sure these girls would be getting taken to the cinema, taken to the ice skating and doing age-appropriate things like that.
105. The level of resistance that the girls showed to that was quite high, because they had pressures from the community to turn up to do what they were doing. I suppose we would call that grooming now, but that wasn't really something that was acknowledged at the time.
106. I went to the kebab shop with a male who I think may have been the local community police officer. I told the staff what age the girls were, that they were not employing them anymore and the girls wouldn't be coming back. I told them to stop phoning the girls and to take their numbers out their phones. I actually stood whilst they took the numbers out their phones. I was trying to make it easy for the girls to get away from it.
107. That should have been enough to warn the people from the takeaway shop off if it was all above board, but it wasn't as they were still persisting and phoning them. The guys were coming to the end of the driveway at Gryffe in their cars, and the girls were

running down to meet them. I remember either the cook or the cleaner saying she had seen one of these girls getting dropped off by a man in a car. That was why we got the police involved.

108. When the police got involved, they were nodding along to what I thought was the case and were not dismissive at all. Albeit it was reported to the police the main thing that was reported was about the staff from the shop failing to stop and desist when we had requested them to do so. That was what I wanted stopped.
109. The police were told that the men were coming to pick them up for their 'shift' at the end of the driveway, which staff couldn't necessarily see but there was a number of times they had been spotted. That had continued to happen after we had been down to tell them to desist.
110. These men from the takeaway did really get warned off by the police and they stopped coming.
111. As another way to try and help solve the issue, I organised quite intensive family work with one of the girls involved as she desperately wanted to get back to her family. I put this in place and we got her home. So, if it continued for her, it would have continued from her home, but I doubt it did because she just really desperately wanted to be back with her mum. Before this, the staff had not done anything on her care plan to make that happen.
112. There was a question mark about all this in my mind and we never fully got to the bottom of it. I felt that the residential worker called RIU was linking the girls up with the takeaway shop. I felt he was telling them to go down there or he could get them a shift down there. I told the police about this. RIU was RIU who is referred to in the documents I was sent. I think he was about thirty-five, he wasn't old.
113. The reason I thought RIU was involved was because, when I was speaking to one of the girls who had been going out all dressed up with the skimpy clothes, I had been telling her that we wouldn't be letting them go to work in the takeaway shop anymore.

I told her we could get her another job, but it wouldn't be there. I told her how I was worried about how she was dressed when she went there.

114. It was during this conversation that she told me that it was RIU who had got her the job there. I would have given her an opportunity to tell me if there was anything sexual going on by leading the questioning but she never confirmed that. None of the three girls involved did.
115. As well as the girl saying RIU got her the job, one of the boys in Gryffe had referred to him as being pals with the guy at the takeaway shop. Both other girls denied RIU had any role in this.
116. I held a staff meeting about it. I told them I was concerned about what was going on and that the absconding might be related to sexual exploitation. RIU was argumentative and dismissive of it and said that it was a load of rubbish.
117. There wasn't anything else to suggest his involvement with the takeaway shop other than one girls saying he had got her the job there.
118. The girls were not being truthful about the whole takeaway shop goings on as they were trying to hide things and may even have been scared to say certain things, so it was all very murky. It was never really clear what was going on.
119. I did find RIU a bit sleazy. I was letting him know, very overtly that I was very concerned about the girls and was very concerned about his role in linking the girls up with the takeaway shop but RIU denied it.
120. There were a lot of things about him that weren't right and I spoke to him about them. I spoke to him about why RHT would think it was alright to tell him about spitting in the child's water and also about his scruffy appearance.
121. RIU didn't receive any complaints of ill treatment that I was made aware of from young people, but I was aware he was involved in a quite a few incidents of restraint.

He was quite a big heavy guy. I looked into that and often he was on shift with HGF and Veronica. They would start a fight by riling the young people up and he was left to deal with it. I moved him on from working with the two of them to work with a better female worker, Margaret McLaughlin. I did that because of the fights and restraints but also because I did believe he had something to do with linking the girls up with the takeaway. The restraints he tended to be involved in were with the older boys. They did stop after he began working with Margaret, so I don't think he had anything to do with initiating them.

122. It wasn't long after this that he just up and left Gryffe. People that don't want to be managed properly do that, so he went and that was the best thing for everybody.
123. I don't know if he gave a reason for leaving. One of the other things that I had to speak to him about was his timekeeping. He never got to his work on time. He was always late because he was one of these guys that had another job on the side. His girlfriend was a florist and he was doing the early morning run to get the fresh flowers, so I think it was easy enough for him to leave.
124. I don't know if the police had actually opened an enquiry into what we had reported about the allegations but I do know for absolute sure that the police went to the takeaway and absolutely put a stop to them coming up to the home or contacting the girls. That had been an every night problem but stopped after the police went and warned them.
125. There wouldn't have been too much time between the men no longer coming for the girls and RIU leaving. He had been named to the police and told of our suspicions. I have no idea if the police spoke to RIU but would not be surprised if the two things were related. I think he left around the time I finished my review of Gryffe and I was only there for three months.
126. I don't know the name of the guy that ran the takeaway or any of the people that worked there but maybe the police will have a record since we reported it to them.

127. That potential child sexual exploitation was probably one of the worst things that was going on there.

Absconding

128. There had been an explosion in terms of absconding and the staff were very complacent about it, which I found very concerning.
129. Staff reported to me that residents would often go to stay overnight with former residents who lived locally. However, I was not satisfied at all that that was what was happening. I would have been expecting the staff to be going looking for them, but it seemed they weren't.
130. The rate of absconding, primarily in relation to these girls who 'worked' at the takeaway shop would have been one of the reasons that the investigations were asked for in the first place.
131. RHQ [REDACTED] refused to take a reverse phone call from a girl who had absconded. This was one of the girls that I believed was being exploited by the staff at the takeaway shop.
132. The circumstances were that she was missing and RHQ [REDACTED] had telephoned the police almost immediately, despite knowing that she was likely in a particular care leavers girl's house. She was subsequently told off by the police for calling and RHQ [REDACTED] took that to mean that she didn't really need to then do anything about her being missing. The girl who was missing, then telephoned into the home on a reverse charge call and RHQ [REDACTED] was aware who the call was coming from. Inexplicably and wrongly, she refused to take the call.
133. RHQ [REDACTED] recorded in the senior log, the fact that she had the option to take the reverse charge call but had declined it. Each subsequent senior would have read that log, yet no one said anything.

134. When I questioned Paul Crieghton about that he said he hadn't seen the entry in the log and said, "Oh well, she just used her judgement." I would have expected him to be shocked at her not taking the call, but he wasn't. I'd never heard of anything like that. I expect any normal person would have been actively trying to get the young person back and would take any opportunity to take to them and ensure they were safe.
135. I thought she should have been sacked for that, but she wasn't. During the investigatory interview, it was put to RHQ that the safety of the girl was paramount, though the words grooming would not have been used then. Her reaction was one of shrugging her shoulders and saying that she believed the girl was just expecting a taxi or lift back to the home. There was no cognisance from her of the risk or danger that the girl may have been subjected to.
136. In interview she went on to say how she hated her job and just wanted to retire. I recall she wasn't that bothered. She received a six-month written warning about the incident but retired shortly afterwards. I think she may have gone off sick during the disciplinary and didn't return to Gryffe.
137. The staff at Gryffe had not been keeping proper records of absconders. That turned out to be one of the disciplinary matters levelled against Paul Crieghton.
138. There was supposed to be an absconder record created which should show whether an absconder had been assessed for police involvement and when that police involvement should happen. My course of action would have been if a certain girl had absconded and I thought that she was round the corner at the flat of a previous resident, I was not going to immediately get the police involved with all lights flashing. However, if I thought the girl was away with a guy from the kebab shop, I was definitely going to get them involved.
139. There was meant to be an assessment of where people were. It wasn't uncommon for children in homes to go to see their pals that had previously been in the home, but were now in independent living, and for the young people to try and stay there. The

staff would just go and get them back, but again that wasn't what was happening at Gryffe.

140. The way they did it at Gryffe was that they recorded the absconders in the senior log. This was one logbook that they used for everything, so trying to extricate information was impossible because it was just a rolling log of everything and they never used the proper formats for that. It would be recorded in that log when the absconders had come back.
141. The cook or the cleaner said she had seen one of these girls getting dropped off by a man in a car. I mean you don't get dropped off by a man in a car if you've been at your pal's flat.
142. Occasionally the police would complain about continually getting called out about absconders. Sometimes social work headquarters would get told by the police that one of your units had constant absconders and they were getting called out.
143. The staff had a bit of a 'get out' when it came to the way they handled absconders because there had been a lack of clarity about when to phone the police after an absconder came to light. Joan Lafferty had told the staff that they could wait twenty-four hours before reporting them missing to the police.
144. Now she probably meant that as if they really believed that the absconder was round the corner at a pal's flat, they could wait twenty four hours but that was taken to mean they didn't need to report any absconder for twenty four hours and they didn't need to take the reverse charges call. It was very lackadaisical and uncaring of them.

Other Staff

John Boreland

145. John Boreland was another staff member at Gryffe who, like RIU, was a bit sleazy. I remember zGNR thought he was sleazy too. When you are working with older girls there has to be clear boundaries and I'm not sure either him or RIU had them. I would go so far as to say I found them a bit sleazy and 'unboundaried' with the young girls. They didn't work together, and I don't think they were friends.

IFI

146. IFI was a day shift residential worker. When I went there to do the review, he was off sick. I think I overlapped with him for two weeks and I think he kept his head down. There was a bit of a joke because zGNR told me that every time I went into Gryffe, IFI ran for the hills, so I barely saw him. He was a nervous guy, was jumpy as a cat. As he made himself scarce when I was there, I saw very little of him interacting with the kids but from what I did see there was nothing strange and I can't say I saw him doing anything good or bad.
147. I never heard from any other staff or residents that he was being abusive or overly disciplinarian, but what I would say was that he was a tall thin guy and some of the boys that were in Gryffe at the time would have made mincemeat out of him.

KRS

148. KRS was mainly a nightshift residential worker but also did a lot of overtime shifts.
149. She came to Newfield because it was decided, not by me, when Gryffe was closing, to split what wasn't a good team up. She got a nightshift position and she was okay, but she was a 'cold fish.' She was a young attractive woman so the teenage girls should have liked her in theory, but in practice they didn't really take to her. She wasn't

big on building relationships. I always thought that was why she was on the nightshift. It wasn't as if she really liked the kids and I always thought that young woman who love the kids don't go on the nightshift. They want to be on days and in amongst the kids. She had a qualification as well so she should have been good, but she wasn't really.

150. I didn't have any concerns about her. I never heard from any other staff or residents that she was being abusive or overly disciplinarian, but I do recall getting her manager to speak to her once on nightshift because a girl said she had been short tempered with her. It was nothing big and she appeared to take it on board.

RFI

151. RFI was a member of staff who was off sick whilst I was doing my investigation. She was in her sixties and nearing retirement age. I never met her but when zGNR was SNR and I had returned to Newfield, zGNR contacted me looking for advice. RFI had given a boy a spoonful of knit shampoo by mistake instead of his actual medication for ADHD. The boy required medical treatment and he was very angry and distraught. As per my advice RFI was sent home and advised this was a disciplinary matter. It was resolved when she elected to retire without ever returning to the unit.

Implementing immediate changes

152. From my investigation and time basically running Gryffe, there were a number of things that had to be stopped dead across the board and new rules put in place. Things like people pulling covers off children in their beds. Another thing was the rules they had in place, like if people came inside and didn't put their slippers on they would have pocket money deducted. Again, that is something bad from the 1980's and it was really old fashioned.

153. If somebody damaged or vandalised something, they would get their pocket money taken off them for a year, or at least a very long time. They kept these punishments running for ages. I had decided that we were going to just write them all off because it was absolutely ridiculous. I told the key workers to go through why their kids had these sanctions; tell them it wasn't a great idea to vandalise the place but we're not going to have these kinds of sanctions anymore. They weren't wanting to do that and in fact one of them went off sick to avoid taking a sanction off a kid. They were really quite punitive. I imposed new rules about sanctions.
154. The kids didn't like this, but there had to be rules put in place about activities and supervision. The big boys and wee boys had been all round that house hitting each other, giving each other a 'dunt', and the staff didn't even have a clue where they were in the building. It was a difficult to manage building.
155. Another rule we had to undo was the one that if you didn't eat your dinner, you couldn't get your supper which again, was really old fashioned.
156. I've been in places before where we have stopped long standing rules. The staff are usually happy with that because they agreed it was time to update ourselves and stop doing these certain things. Not at Gryffe. The only people that were happy were the cooks and the cleaners because they were a bit more nurturing.
157. Margaret McLaughlin came back after being off sick and that picked things up because she was obviously quite good. She was one of the seniors and when she had gone off sick it had caused a bit of a collapse. In actual fact, she was the only member of staff I could say anything positive about. She did build relationships with the kids. Her coming back did improve things. She did manage the staff and was quite good even although there were rumours about her having had kids at her house.
158. When I was speaking to staff about what was right or being done right at Gryffe she was the only one that defended the place and said she was trying her best. As I said the rest of them, were 'dobbing' each other in and they didn't have any kind of loyalty. It was quite strange.

159. At Gryffe, it was more neglect. If I really sum it up, it was more an absence of the proper caring relationship. There was a lack of boundaries as well, because maybe where there were good relationships they maybe weren't quite right. There definitely was something about kids going to staff's houses previously, that I never got to the bottom of.
160. Kids had said that this particular 'top boy' and somebody else had been going to a couple of staff member's homes, but the kids who were supposed to have gone to the homes, and the particular members of staff, all denied it. I had to treat several things that had happened in the past as being in the past and from then on going forward if there had been any misunderstanding about practices in the past, then going forward, going to staff homes and certain other practices would not happen from now on.
161. If there was any misunderstanding about the rules around the use of the quiet room I felt it best to just stop using it all together. It was a big building; we did not need to drag kids to that room.
162. I had to set a lot of parameters and I had to drag the staff into engaging with the kids and get their tails out the office. Even initially after imposing new rules, if I turned up at Gryffe unexpectedly, the staff were in that office. They were virtually married to that office. That was a job and a half to get them out and engaging.

Report

163. After doing my investigation, I did my report and made catch all recommendations about who needed to attend disciplinary hearings.
164. As I don't have the report, I can't recall exactly how I did it. I am going by what my practice would have been. This was the first time I ever had to do anything like this, and I'm sure my report wasn't as comprehensive as it would have been if I had a bit more experience. I would have framed everything with the grounds for disciplinary.

165. I would have listed what all the issues were, and it must have formed the disciplinary grounds, despite them not all meeting the threshold for disciplinary.
166. I named the people that I thought should face disciplinary procedures and three of them: Paul Crieghton, RHT [REDACTED] and RHQ [REDACTED] (not related to RHT [REDACTED]) did face disciplinary hearings.
167. RHT [REDACTED] was disciplined but as far as I could see, I don't think he was named in the documents I was sent by the Inquiry.
168. There was a bit of debate about whether Diane Ralph should face disciplinary proceedings. She was in charge a lot of the time, but I thought not, because although she had been presiding over it and it wasn't very good, she was like a 'one man band' trying to keep the place going. It would have been unfair although she had overlooked lots of things she shouldn't have, but that wasn't through complete laziness, it was through her being overwhelmed.

Investigation Outcomes / Changes

169. In-house training was improved by a training agenda being devised and implemented. This included improvements in all areas but in particular, to TCI training and safeguarding.
170. There was a whole lot of sorting out of basic routines and rules. Activity structures were put in place.
171. There was specific thought given about how the staff would be split up when Gryffe was closing and they were moving to the smaller units.
172. There was immediate movement of some of the young people, for example, the request was facilitated for the boy who asked to go back to Newfield having been subjected to abuse from RHQ [REDACTED].

173. When I went to Gryffe, I think the number of children was about fourteen or fifteen, but then a flurry of kids went home. By the time I left they were down to about ten kids.
174. The care plans were all reviewed and I think the area teams got a bit of shirring for it because the care plans for the children, were weak.
175. I don't think there had been any complaints raised by the children's individual social workers. What happened was Renfrewshire Council was quite static and a lot of those social workers had been going in and out of Gryffe for years and probably quite liked it. A lot of them knew Paul Crieghton and he would have been absolutely well-known and well-liked. It was probably similar to his line manager in that he was a well-known face who talked a good game.
176. Sheena Duncan was constantly talking to social workers and telling them they were the vanguard of safeguarding, that part of their responsibilities was that if they were going in and out of units, they were an extra pair of eyes. That was an absolute theme for her, and she talked to them about that all the time. If she had them together for any other purposes, she would also talk to them about it. That was a constant. By that time, she was maybe there a year and a half, so folk were just getting used to higher and better standards.
177. Gryffe had been a feature on the landscape for a long, long time and these social workers would have been in and out it a hundred times.
178. There were some immediate improvements with staff with some picking themselves up. For some, there was a realisation about what they were supposed to be doing with the children but there were others who didn't come to that realisation or were a lot slower. HGF didn't change, RIU didn't change, though he then left as Diane Ralph and RHQ.
179. In the end, Paul Crieghton was demoted down to a main grade worker and was sent to Newfield, where I had him for the next couple of years. Even after everything that had happened, he was still so lazy. He was actually not unlikeable from the kids' point

of view because he was musical, he was quite knowledgeable about things and he could chat, but still lazy.

180. Once Paul Crieghton moved to Newfield and I was back, I still had problems with him. Basically, the way he saw it was that I had taken action that led to him being demoted so he said "I hope you find it comfortable having me here, because anything that is wrong with your practice, I will be right on top off it." I told him I was fine with that as there was nothing wrong with my practice, but he could dig in.
181. I think he thought he could nit-pick about everything that I didn't do properly. He did it once or twice but it never actually got as far as me because other staff just told him, "Aw shut up, away you go, take a hike, she's more of a manager than you" and that was getting fed back to me.
182. To be fair to him, there were no issues with him and the young people. He was quite likeable as far as they were concerned because he didn't bother upholding the rules, let them away with whatever and he would strum his guitar.
183. He was a highly qualified guy, more so than me and was a teacher as well so what he did do that was positive, was that he would go down to the school and contribute to lessons. The kids that were academic did actually quite like him. As long as you didn't ask him to do anything that felt like work, he was fine. He could write a report and if you really set him to do something he could actually do it. It wasn't a lack of ability; he was just really lazy.
184. It's not great having somebody working for you that you have just disciplined but it was alright.
185. I gave over my best SNR [REDACTED] from Newfield, zGNR [REDACTED], to work as SNR [REDACTED] at Gryffe as I was writing up my report. It was a job to get it sorted and I wanted it to stay like it had got to. I knew if I had taken any pressure off the staff they would have been back in the office with their feet up and the kids running about.

186. When they were splitting the kids into smaller units, I said to zGNR that when they split the staff up she should keep RHT and RIU as they were both still there at that stage. I told her that the two of them required somebody keeping an eye on them. RIU did then leave and she did keep RHT.
187. RHT seemed to reinvent himself under zGNR s SNR. He wasn't workshy like a lot of the rest of them; he just didn't have the right values and attributes. However, once zGNR SNR him, his outward demeanour was okay. I don't think he got into any trouble after that.
188. I took [redacted] and [redacted] back to Newfield and, after the investigation, I returned to my own job there. Shortly thereafter that, I was moved to headquarters for a while.
189. zGNR moved permanently from Newfield to Gryffe. I wasn't happy about losing her, but they needed it because the staff were really not good. She had been there with me as I ran the place for the three months, so I left her there and she SNR it until it closed.
190. Gradually, some of the residents moved back to their parents and one young woman went to secure. It left about eight young people. I think by the end of 1998 Gryffe was closed. They all then moved to Roneil Children's Home Secondary Institutions - to be published later
Secondary Institutions - to be published later

Disciplinary Hearings

191. As a result of the disciplinary hearings, Paul Crieghton received a punitive disciplinary and was demoted and transferred to Newfield. RHT and RHQ both received a six month written warning.
192. Following my investigation and report, I did feel that the outcomes from it were quite light. I could understand why that might be because it would have been difficult to

sustain them. It's difficult to sustain them at a tribunal because each member of staff could have rightly said they hadn't been properly trained or supported and they could have made a good case for themselves.

193. David Crawford, who was heading up the hearings, is a thorough person and I don't think he would have intentionally let them off lightly. I have known him a long time and I don't believe that would be the way that he would do things.
194. It is my speculation that it would be difficult to uphold punitive disciplinary outcomes at a tribunal because none of them had been properly managed. I think he went for outcomes that were short of dismissal because it probably wouldn't have met that test. If you do that and lose, you are in a worse position because you have to give them their jobs back and a clean slate. Maybe that was the wisdom behind his decision making.
195. The disciplinary hearings were handled in a funny way. I wasn't asked to present them, I was asked to be a management witness which is not necessarily what I would have expected. I would have expected that I would have carried out the investigation and then presented the issues, but that's not how it transpired.
196. If it was up to me, I would have probably dismissed RHQ [REDACTED] for gross misconduct. The actions of RHQ [REDACTED] not taking that reverse charge telephone call and banging the pots and pans and putting a radio to a deaf boy's ears was, in my opinion, worthy of a dismissal. There was no excuse for that and I would have thought you could have defended a dismissal for this.
197. The rest I could understand because of nobody being managed properly but not that one. I do think that's the one that could have been argued. Although, I think it was quite evident she was going to leave anyway and retire, so maybe it was pragmatic.
198. RHT [REDACTED] got disciplined for two or three things that were upheld. Kids had complained about him, but I can't remember them all. One of them was for saying to RIU [REDACTED] that he was going to spit in a kid's water jug.

199. I felt the disciplinaries were a wee bit partial given the issues there were in the unit. There were actually more things that could have been in them. They were quite light, and I felt the outcomes were quite light.
200. If I was to speculate, I think it was because there was an 'up the hill thing' that happened. RHQ was saying she was knackered, that she had been assaulted, never got debriefed, never got any support and was at her wits end. So, she pushed that up to the management.
201. Everybody in that place could push whatever they had done up to Paul Crieghton. Every single person that worked in there could have claimed that they weren't properly managed. That went right up to Paul Crieghton because his line manager wasn't doing a good job either.
202. There was never any discussion of reputational risk being considered and in fact it was quite the opposite. That was in direct contrast to what I subsequently experienced elsewhere.
203. When I was given the job to do at Gryffe, I was up at an office at headquarters to liaise with somebody from the finance team. When I was in the corridor there, I saw Sheena Duncan, the head of Social Work and she said to me, "I hear you are looking into what has been going on at Gryffe."
204. I told her I was and told her a bit about what had been going on with the takeaway shop. I told her I let David Crawford know because these things have a way of finding their way into the local paper. I will never forget that she said to me, "No, if you've got a boil, you keep squeezing it." Her attitude was that it doesn't matter if it is in the local paper. There was no concern about reputational harm.

Concerns regarding Disciplinary Hearings Outcomes

205. The six month written warnings that RHT [REDACTED] and RHQ [REDACTED] received meant that the warnings would be wiped from their record after that six months and nobody in the future would be any the wiser, unless they had personal knowledge of what had happened. I didn't think too much about this at the time, but it is a concern.
206. The whole business of the expunging of disciplinary records is a concern. When I later carried out an investigation into Kerelaw, some staff had spent disciplinarys which were only apparent if you went looking for them and knew where to look. That certainly paints a picture of a bigger problem. Personnel departments were supposed to expunge them but because they were normal humans, they were concerned about what they were expunging so they started having unofficial 'X' Files. If that hadn't happened, some of what came out at Kerelaw would never have been known.
207. There is an example from Kerelaw where John Muldoon had warnings expunged, continued to offend and ended up in prison.
208. There was nothing in RHT [REDACTED] or RHQ [REDACTED]'s records showing they had any disciplinary matters prior to this.
209. There was one entry on Paul Crieghton's record. He was questioned about buying booze from colleagues that must have been, 'off the back of a lorry', but that was it.
210. RHT [REDACTED] continued to work in childcare after being disciplined.
211. RHQ [REDACTED] was older and my recollection is that she went off sick after her disciplinary and never came back because I think she retired. That was for the best.
212. I think HGF [REDACTED] continued to work in care at Gryffe after I was away, but I heard that she continued to be problematic. It was short of anything you would sack her for, but she was moved away from Gryffe into a small unit. It was maybe felt that she would

benefit from only having three or four kids to deal with. Her name always came up later as someone who was causing trouble with the manager or the kids.

213. I was concerned that **RIU** left when there were low-level concerns hanging over him so he never faced any disciplinary action, and he could easily have gone somewhere else and got a job in childcare. There might have been a reference request or not. There were none of the safeguards that later became available.

214. I don't believe **RIU** went on to work in a childcare setting after leaving Gryffe, but I can't be sure. I think he went to work with his girlfriend in a florist shop.

Other information

215. 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... *2nd February 2026.*