

Thursday, 18 June 2026

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(10.02 am)
LADY SMITH: Good morning, and welcome back to Phase 10 of our case study hearings.

Now, before I turn to closing submissions in Phase 10, there are one or two things that I'd like to say.

Now, Phase 10, of course, has been running since December of last year and, by the end of this week, its hearings in public will have been completed.

Phase 10's focused on the provision of residential care for children and young people in establishments run by local authorities and establishments run by voluntary providers used by local authorities and others to place children in care.

Over the course of the last 46 days, or the 46 days, I should say, extending from December until now, evidence was heard relating to over 200 witnesses and we've covered around 20-odd establishments. We have heard, amongst that, the evidence of some 167 applicants.

Today, before I turn to the Phase 10 closing submissions, I'd like to just say something about where we're going next, after this phase.

We'll be going to Phase 11, and Phase 11 is about

1 protecting children in care in Scotland from abuse,
2 present and future. It will begin in the latter part of
3 this year and it's going to focus in particular on
4 paragraphs 6 and 7 of our Terms of Reference, and that
5 means that it will include considering the extent to
6 which failures by state or non-state institutions to
7 protect children in care in Scotland from abuse has been
8 addressed by changes to practice, policy or legislation,
9 and considering whether any further changes in practice,
10 policy or legislation are necessary in order to protect
11 children in care in Scotland from abuse in the future.

12 In responding to our Terms of Reference thus far, we
13 have ingathered a substantial body of evidence in
14 relation to a wide range of residential care settings
15 and I have already been able to make findings, as
16 published in 16 separate volumes thus far.

17 My 17th volume of findings is due to be published
18 later this year and further volumes are already in
19 preparation.

20 During Phase 11, there's going to be a focus on
21 these two paragraphs of our Terms of Reference that
22 I mentioned a moment ago and we're going to look at the
23 failures of state and non-state institutions to protect
24 children in care and whether they have been addressed
25 and whether further changes are needed, and that means

1 that the structure of Phase 11 hearings will also allow
2 us to look at some specific themes. For example, later
3 this year we will consider why children abuse other
4 children.

5 We've already heard and presented much evidence
6 about the abuse of children in care by other children in
7 our case studies, that's across the board in our case
8 studies, and I've made numerous findings about it. And
9 what I want to do now is explore the important question
10 of why it is that that happens.

11 Also, I recently made an announcement in relation to
12 our work regarding the exploitation of children in care
13 and we plan to include that in our presentation of
14 Phase 11.

15 By 'exploitation', as I have already said in the
16 announcement about that work a couple of months ago,
17 I mean a type of abuse in which a single person, or
18 groups of people, persuade or force a child to engage in
19 sexual or other activity. When groups of people do
20 this, they may be referred to as 'grooming gangs'.

21 So long as the exploited child was in care, we can
22 investigate the abuse within our Terms of Reference,
23 even if the grooming or the exploitation took place
24 outside the placement or a foster home, for example.

25 Now, those of you who have been keeping a close eye

1 on Phase 10 may recall we've had some evidence during
2 Phase 10 about the exploitation of children in care, but
3 there have been instances of that evidence throughout
4 other case studies and, indeed, in written evidence
5 which we have ingathered.

6 And we can also investigate allegations of such
7 abuse which happened before the end of December 2014 and
8 continued after that date. Sometimes, people are
9 concerned that they may be turned away by us if they're
10 talking about abuse that carried on in 2016, 2017 or
11 last year. But under our Terms of Reference, if that's
12 a continuum from before the end of 2014, there's no
13 problem with us looking into that.

14 So we plan to focus on that topic, the exploitation
15 of children in care, in our Phase 11 hearings in the
16 early part of 2027.

17 Now, I've mentioned just two topics so far, but
18 that's not to say we're only going to look at two topics
19 in Phase 11, they're just examples, and other hearings
20 in relation to specific topics will also be included in
21 Phase 11 and we'll announce details of those in due
22 course.

23 But, as I said, we now need to finish Phase 10 and
24 I'm going to invite closing submissions and, naturally,
25 I'm going to start with counsel to the Inquiry, senior

1 counsel to the Inquiry, and invite Mr MacAulay to
2 address me.

3 Mr MacAulay.

4 Submissions from Mr MacAulay

5 MR MACAULAY: My Lady.

6 As your Ladyship has just mentioned, the focus of
7 this case study has been on 20 establishments, and with
8 the possible exception of Ponton House, these were
9 children's homes, even Fornethy House, which was
10 a residential school, or may ostensibly have been
11 a residential school, but it was a home to the children
12 during their time.

13 LADY SMITH: It was a school which provided accommodation
14 that was linked to the school.

15 MR MACAULAY: Indeed.

16 Now, my Lady, seven local authorities managed 14 of
17 these establishments and the remaining six were managed
18 by voluntary providers.

19 Your Ladyship has set out the relevant statistics on
20 how long this case study has taken and the number of
21 witnesses. It is worth pointing out that nine convicted
22 abusers have given evidence.

23 Other convicted abusers have either died or were
24 unable to give evidence due to health reasons, and
25 I will be returning to the evidence about the

1 convictions shortly.

2 But what these statistics do show is that this has
3 been a significant case study and now those with leave
4 to appear have the opportunity of making closing
5 submissions and they have been provided with a timeline
6 that advises them of the order in which submissions are
7 expected to be made.

8 Now, your Ladyship has just announced and mentioned
9 that the topic of the exploitation in the community of
10 children in the care system will feature in the next
11 phase of the Inquiry and as your Ladyship has said, that
12 topic has already been a theme in the course of this
13 Inquiry and as your Ladyship has indicated, the
14 intention now is to have a particular focus on that
15 topic in the next phase.

16 And indeed, as your Ladyship has just mentioned, the
17 exploitation of children in the community has featured
18 in this case study and in previous case studies, and can
19 I mention just a couple of examples.

20 Carol McCaig was asked to carry out an investigation
21 into Gryffe Castle Children's Home in relation to
22 a range of issues, including the supervision and
23 management of the staff, and that was in early 1998.
24 And when she took up her position, she described Gryffe
25 in evidence as 'a shambles'. But what she also

1 discovered was the prevalence of what she described as
2 'child exploitation and grooming'. And what she found
3 was that 14 and 15-year-old girls were going out of the
4 home 'dressed as hookers', ostensibly to some sort of
5 work at a local takeaway, but in fact meeting older men
6 and returning in cars late at night or early the
7 following morning and her conclusion was that these
8 girls were being sexually exploited in the community,
9 and one has to bear in mind these were vulnerable
10 children.

11 Another example relates to the evidence that focused
12 on Ponton House and its connection with Tam Paton and
13 his associates, and it is evident that children in the
14 care system were being sexually exploited.

15 'Murphy', who gave evidence, alleged that he was
16 sexually abused by Tam Paton and John Wilson was
17 convicted on two charges involving the sexual abuse of
18 'Murphy', along with others whose identities were
19 unknown, and 'Murphy' was aged 14 at the time.

20 And another example, in relation to Dunclutha, there
21 was evidence of serious sexual abuse of a child at
22 Dunclutha -- in the community by sailors attached to the
23 local naval base. 'Peter' described how he was groomed
24 by being given goody bags by two individuals, he
25 referred to them initially as captains, and how they

1 were then entrusted to take him away at weekends and
2 then in due course he was taken to what he described as
3 a villa where he was seriously sexually abused. He was
4 raped by one of the individuals in the presence of
5 another person.

6 So, my Lady, these are just examples, in this case
7 study, of how children in the care system were being
8 targeted by adults in the community.

9 Now, my Lady, if I can look at the present position
10 regarding the 20 establishments that have been looked at
11 in the course of the evidence, only Dunclutha and
12 Coblehaugh are still in existence, but now they are
13 housed in different modern buildings designed to
14 accommodate a small number of children.

15 LADY SMITH: That's a theme in the changes that have
16 occurred since the events we've heard of in a number of
17 institutions, that if there's ongoing provision, they're
18 in a much smaller -- on a much smaller scale; children
19 are not in big homes with lots of children, overcrowding
20 and the like.

21 MR MACAULAY: Yes. And that the children's home landscape
22 in particular has been transformed, from one of the
23 large establishments that your Ladyship has just
24 mentioned to much smaller units.

25 It's worth bearing in mind, of course, that that

1 was the vision of Clyde --

2 LADY SMITH: Yes.

3 MR MACAULAY: -- in 1946, and it's a vision that has taken
4 over half a century to materialise, with the result that
5 large, poorly staffed, institutionalised establishments
6 continued to provide a fertile environment for abuse.

7 My Lady, at the outset of this case study, I did
8 mention that in contrast to other case studies, there
9 would not be the same volume of applicant evidence.
10 However, notwithstanding that absence, there has been
11 clear evidence of serious and widespread abuse,
12 primarily because of the serious convictions of abusers
13 who worked in most of the establishments under review.
14 And by way of statistics, in relation to 13 of the
15 establishments included in this case study, at least
16 15 individuals have been convicted of serious offences,
17 mainly of a sexual nature. Fornethy is the main
18 exception, where the convictions there were for cruel
19 and unnatural treatment.

20 Now, on the issue of numbers who have provided
21 evidence to the Inquiry, there are two exceptions to the
22 general position where few applicants came forward.
23 19 applicants, for example, did give evidence in
24 connection with Lagarie, and 40 in connection with
25 Fornethy. And it may be the case that complainers who

1 had given evidence in earlier trials, who did not come
2 forward, were reluctant to engage with the Inquiry
3 because of their trial experiences. And Fornethy,
4 of course, was a much more recent trial, where the
5 procedures for protecting witnesses were very different
6 to the earlier days.

7 Now, in relation to Lagarie, in addition to the
8 evidence provided by applicants, your Ladyship has also
9 had the benefit of Mark Daly's evidence and the
10 insightful documentary that he produced, 'Suffer the
11 Children'. And it is rather telling that at one point
12 Mark said in evidence, and I'll quote:

13 'In the years, many years, I've been doing this,
14 I haven't encountered anyone, I think, as evil as
15 William Barrie and his wife, and the levels of depravity
16 and cruelty that I heard about at Lagarie are on
17 a different level.'

18 Now, William Barrie escaped being held accountable
19 by his death, but Mark was rather shocked to learn, when
20 it was put to him during his evidence, that there had
21 been a Crown decision not to prosecute Mrs Barrie, who
22 was still alive, a decision apparently taken in the
23 public interest, and it may be at some point the Crown
24 may wish to comment on that.

25 Can I then, my Lady, really focus on the matter of

1 convictions and as I've just mentioned, at least
2 15 individuals have been convicted on charges of abuse
3 at most of the establishments under consideration. And
4 in the main, these convicted abusers were people in
5 leadership roles, and I'll look at some examples simply
6 to highlight the scale of the abuse.

7 David Murphy was convicted on 30 charges involving
8 sexual abuse. He pled guilty to these charges on
9 an indictment containing 60 charges, and these offences
10 were in relation to children at St Margaret's. The
11 period ranged from 1960 to 1973, and 19 of the
12 complainers were at St Margaret's, some were on more
13 than one charge, and he was sentenced to 15 years'
14 imprisonment on 2 March 2001.

15 And the telling point is this: that only one of the
16 complainers at his trial was an applicant, and that
17 underscores the point that the extent of the abuse can
18 really only be looked at under reference to the
19 convictions.

20 And it is also the case that at St Margaret's,
21 Trevor Francis was an abuser and he was convicted on
22 five charges involving four complainers at St Margaret's
23 in the period 1973 to 1975 and again, in May 2017, and
24 he was convicted of three charges, which were assault,
25 but two had a sexual element. And again, none of these

1 complainers have engaged with the Inquiry.

2 An interesting example is Peter Harley. He was the
3 officer-in-charge at Merkland Children's Home. He pled
4 guilty to 17 charges involving sexual abuse and he was
5 sentenced to 15 years' imprisonment on 22 April 1996.
6 He had faced an indictment of 42 charges and these
7 charges included 13 complainers who had been children at
8 Merkland.

9 In August 2022, he was again convicted on three
10 charges involving the sexual abuse of two complainers at
11 Merkland and he was sentenced to three years for those
12 offences.

13 So the total period covered by those charges ranged
14 from 1977 to 1982. None of the 16 complainers in total
15 was an applicant.

16 At the time of his 2022 conviction, Peter Harley was
17 serving an eight-year sentence for offences involving
18 the sexual abuse of boys at a school in Cardiff. That
19 had been imposed in December 2020 and again he had pled
20 guilty to those charges.

21 Now, unusually for convicted abusers, Peter Harley
22 was able to face up to his behaviour and he was able to
23 provide some insight into his offending. He said, for
24 example, there was a lack of staff and supervision at
25 Merkland. He was attracted to boys:

1 'I was only interested really in younger children
2 that were innocent.'

3 LADY SMITH: Yes.

4 MR MACAULAY: And:

5 'I stole their innocence from them.'

6 And he said again:

7 'If they were children that I thought would report
8 it straightaway, I would stay away from them.'

9 He also accepted that he was not qualified to do the
10 job and that he should never have been offered the
11 position. So he does provide some insight into the mind
12 of a person who was a prolific abuser.

13 Can I say in relation to this particular council,
14 Dumfries & Galloway, uniquely, this council developed
15 a bespoke ex gratia compensation scheme in the late
16 2000s, in recognition of its failure to protect children
17 in care. And according to what is set out in the
18 council's written submissions, over £1 million has been
19 paid out to 52 former residents. It's a major
20 achievement.

21 LADY SMITH: Yes. It's a powerful statement of their true
22 recognition of what happened and what the impact has
23 been. Quite remarkable, and a small council took it
24 upon themselves to do this.

25 MR MACAULAY: Now, my Lady, other serial abusers included

1 Ian Samson, who was essentially in charge at The Lord
2 and Lady Polwarth Home, and he was found guilty after
3 trial on 22 charges involving sexual abuse, and ten of
4 those charges involved children who had been in his care
5 and in August 2013, he was sentenced to 14 years'
6 imprisonment.

7 The telling thing about his position is that he had
8 a number of previous convictions involving indecent
9 exposure before he went to work at Lord and Lady
10 Polwarth. And again, my Lady, although he faced
11 a significant number of charges involving The Lord and
12 Lady Polwarth Home, no complainers have come forward to
13 engage as applicants.

14 Another serial abuser was Gordon Knott, who was --
15 had been at Merkland and in charge at Glenallan, and he
16 faced two trials in connection with complainers who had
17 been at these establishments and he was found guilty
18 of -- on 11 charges in respect of children in his care.
19 In his first trial he was sentenced to 16 years'
20 imprisonment, and in his second trial, to four years.

21 Now, four complainers have come forward as
22 applicants in connection with, in particular, Glenallan
23 and the period covered by his abuse ranged from 1973 to
24 1983.

25 And can I just make one point about this abuser:

1 a particularly serious allegation made against him is
2 that he induced children to engage in sexual activity
3 with each other, and, in particular, induced a brother
4 and sister to have sexual intercourse to the extent that
5 it became normalised behaviour and that, according to
6 the evidence, had a devastating impact on the lives of
7 the brother, in particular, but also the sister, once
8 they realised the magnitude of what they had been
9 induced to do.

10 Now, your Ladyship may find support for that
11 evidence -- which, of course, Mr Knott denies the
12 allegation -- in the fact that the moving images that
13 formed the basis of an indecent photograph charge on
14 which he was found guilty involved children engaging in
15 sexual activity with each other. And that might assist
16 your Ladyship when she comes to look at that particular
17 matter.

18 It can also be said that Brian MacLennan was
19 convicted on two charges at -- I think I -- did I say
20 Merkland? I meant to say -- I said Merkland, I meant
21 Clerwood.

22 LADY SMITH: You meant Clerwood.

23 MR MACAULAY: Another prolific abuser was John Marshall. He
24 was convicted on 13 charges involving sexual abuse of
25 children at Eversley and Downcraig and that involved

1 12 complainers. Again, none of the complainers was
2 an applicant.

3 He had pled guilty and on 23 November 2006 he was
4 sentenced to life imprisonment with a minimum period of
5 12 years. And that sentence, the severity of the
6 sentence reflected the fact that some of the charges
7 involved not just a named complainer, but also other
8 children being induced to engage in sexual activity with
9 each other. And this was over a period from 1974 to
10 1983 and he was convicted of taking photographs of that
11 abuse.

12 Looking at Bellshill, Edward Stanton was working at
13 Bellshill from 1985 to 1988 and thereafter in two other
14 children's homes, and previously had worked at a home in
15 Formby, where he was convicted in 1996 on 11 charges of
16 indecent assault. And he had other convictions
17 involving the making and processing of indecent images
18 of children.

19 He was convicted in Scotland on 11 charges,
20 including nine charges of the sexual abuse of children
21 at the three children's homes, including three charges
22 involving the sexual abuse of girls at Bellshill during
23 his time there in 1985 to 1988, and he was sentenced to
24 15 years' imprisonment.

25 He did accept, appeared to accept, that he did abuse

1 children at Bellshill, but not to the extent to which he
2 was convicted.

3 Oddly, he appeared to accept that he touched boys'
4 penises at Bellshill, although he had not been charged
5 or convicted with that.

6 Other convictions in relation to Bellshill include
7 Edward Doherty, who was convicted of eight charges,
8 involving three complainers, which involved sexual
9 touching; and RBP, who was convicted on five
10 charges, involving five complainers, one of whom was
11 an applicant, and he was sentenced to 30 months'
12 imprisonment.

13 At Redheugh, which was run by the Salvation Army,
14 Stewart Burgess was convicted on three charges involving
15 the sexual abuse of two boys at Redheugh, and on 2 July
16 2008 he was sentenced to 10 years' imprisonment, and the
17 period covered 1986 to 1990. No applicants have come
18 forward in connection with that -- in relation to the
19 complainers.

20 He was subsequently convicted on one charge
21 involving sexual abuse at Redheugh and he was sentenced
22 to 42 months' imprisonment, and the complainer there was
23 an applicant.

24 I understand that the Salvation Army accept that
25 there was sexual abuse by staff other than

1 Stewart Burgess at Redheugh.

2 LADY SMITH: Yes, they have expressly written to confirm
3 that.

4 MR MACAULAY: There are other examples. Peter Murray, for
5 example, who was at Colonsay Children's Home, he was
6 sentenced to 10 years' imprisonment for serious
7 sexual-related offences.

8 Alistair Findlay, who was at Park Lodge, was
9 convicted on four charges involving three complainers,
10 two of whom were applicants, and he had other
11 convictions unrelated to Park Lodge.

12 And more recently, your Ladyship will have heard the
13 evidence about Fornethy and, in particular, Patricia
14 Baxter. She was convicted on 18 charges of cruel and
15 unnatural treatment, in relation to 18 complainers at
16 Fornethy, covering a period from 1969 to 1984. She had
17 faced an indictment containing 24 charges, and nine of
18 the complainers have provided to the evidence -- have
19 provided evidence to the Inquiry and I think a total of
20 12 applicants, including those nine complainers, have
21 given oral evidence, and 28 applicants' statements were
22 read in.

23 This is perhaps one example where the convictions --
24 the complainers who were involved in the convictions
25 also came forward in numbers to give evidence to the

1 Inquiry.

2 LADY SMITH: Yes.

3 MR MACAULAY: And just focusing on Fornethy for a moment or
4 two, in light of the evidence, because although Fornethy
5 has been described by some as a convalescence home, that
6 description does not accord with the evidence, and
7 certainly from the early 1960s when children were being
8 sent there. It did not -- it was not a convalescent
9 home.

10 LADY SMITH: No.

11 MR MACAULAY: And I think, my understanding of the Glasgow
12 City Council's submission, if it's correct, that they do
13 appear to accept that to describe Fornethy as
14 a convalescent home is, on the evidence, a misnomer.

15 LADY SMITH: The relevant local authorities themselves, the
16 corporations, Strathclyde Regional Council after that,
17 entitled it a residential school.

18 MR MACAULAY: Yes.

19 LADY SMITH: And it was part of their scheme of residential
20 schools --

21 MR MACAULAY: And that's been the evidence.

22 LADY SMITH: -- for residential education.

23 MR MACAULAY: Yes, although the description, 'education',
24 might not properly reflect what actually happened in
25 reality, but that was the intention.

1 LADY SMITH: Run by a headteacher, employees were teachers,
2 there were classroom sessions in the mornings at least;
3 yes.

4 MR MACAULAY: So, my Lady, can I provide this overview.

5 The evidence led, in conjunction with the
6 significant numbers of convictions that I've made some
7 reference to, paint a picture of extensive sexual,
8 physical and emotional abuse of children in the
9 establishments covered by this case study and although
10 I haven't focused on the physical abuse to any extent,
11 some of that abuse has been described as 'brutal' by
12 applicants.

13 And in addition to the abuse, there are consistent
14 themes that echo previous case studies. For example,
15 force-feeding, which of course is abusive. The
16 humiliation of bed-wetters. Derogatory comments about
17 punishment -- about families. And in some cases,
18 delayed punishments.

19 And can I also submit, my Lady, that across the
20 establishments looked at, there is evidence of a culture
21 of abuse that not just involved the abusers, but also
22 others who were not abusers, who appeared to have become
23 conditioned to stay silent.

24 That has been a feature of this case study, the
25 missed opportunities for intervention, and it is

1 a significant aspect, particularly of this case study,
2 that contemporaneous messages or complaints that, if
3 followed up, may have disclosed abuse by persons
4 employed at a number of establishments, and in
5 particular, persons in position of some responsibility.

6 And some examples. In the case of David Murphy at
7 St Margaret's, there were obvious missed opportunities
8 to investigate allegations of abuse. He was ultimately
9 suspended in 1973, but eventually, as your Ladyship
10 heard in the Phase 9 case study, he, apparently without
11 difficulty, moved to work at Linwood Hall, where, as was
12 accepted by Fife Council in its submissions in Phase 9,
13 and I think also in its submissions today, it is
14 accepted that he sexually abused children there over
15 a period of 13 years.

16 At Lord and Lady Polwarth, the nude photographs
17 taken by Ian Samson, of which he was convicted, of
18 a girl lying on his living room carpet, ultimately led
19 to the victim being moved and with Ian Samson remaining
20 in position.

21 The victim was described as being 'a favoured child'
22 and the investigation into the photographs seemed to
23 overlook the obvious and was, on the face of it,
24 superficial.

25 At Colonsay House, Peter Murray was convicted on two

1 charges involving sexual abuse, but a complaint of
2 sexual abuse had been made against him in August 1977
3 and that did prompt an investigation, but he remained in
4 post and the girl concerned was moved.

5 And at Glenallan, the note alleging abuse by
6 Gordon Knott was met by making the victim retract his
7 allegation.

8 And I think the Salvation Army accept that at
9 Redheugh, there was evidence of staff awareness of
10 potential abuse by Stewart Burgess in 1986 and 1988,
11 which was not acted upon.

12 Quite simply, my Lady, it appears from the evidence
13 that the voices of the children were not heard and the
14 stigma attached to being in care was so prejudicial that
15 the children were not believed.

16 Conversely, many children did not report abuse
17 because they had no one to tell, they feared they would
18 not be believed, a fear that reporting abuse would make
19 the situation worse. Thus, when 'Dennis' reported
20 Murphy's abuse and Murphy heard about it, he was beaten.

21 When children at Fornethy wrote letters to complain
22 to parents, these letters were destroyed and letters
23 that were untrue had to be written.

24 Time and time again --

25 LADY SMITH: That evidence was absolutely consistent, time

1 and again.

2 MR MACAULAY: Yes.

3 LADY SMITH: Children were being given a script for their
4 letters home, telling their parents everything was just
5 wonderful, when it wasn't.

6 MR MACAULAY: And when letters were written that did not say
7 that, they were torn up.

8 LADY SMITH: Mm-hmm.

9 MR MACAULAY: Time and time again, my Lady, there has been
10 evidence of poor recruitment practices. Persons
11 appointed without the necessary skills to be involved in
12 the care of children, lack of training and inadequate
13 supervision and oversight.

14 There were staff shortages. Indeed, that was
15 a failure that Peter Harley acknowledged was conducive
16 to undetected abuse.

17 In the main, my Lady, having perused the
18 submissions, written submissions, made today by
19 providers, there does appear to be a general consensus
20 that there were deficiencies along the lines that
21 I've just set out in relation to training and
22 recruitment.

23 My Lady, the final issue I want to look at is impact
24 and again, the evidence here echoes previous case
25 studies. Applicants talked about being 'robbed of their

1 childhoods'. Some suffered -- some had years of
2 suffering and addiction. Personal relationships were
3 difficult to sustain. And there were difficulties in
4 trusting others and, in particular, people in positions
5 of authority.

6 A number of witnesses gave evidence about how
7 overprotective they were of their own children.

8 And the denial of a proper education was referred to
9 by a number and that had an impact on employment
10 opportunities.

11 And some had feelings of guilt and shame, even
12 although they were not in any way at fault.

13 As in previous case studies, the issue of records
14 cropped up and the lack of records in some cases has
15 meant that applicants, former children in care, have
16 been deprived of accessing their personal histories.

17 The absence of records for former Fornethy children
18 has operated against them in their attempts to access
19 the Redress Scheme, although, as the evidence has
20 disclosed, former Fornethy children were able to give
21 reasonably clear evidence of their admissions and
22 discharges from Fornethy. For example, by reference to
23 which primary class they were attending at school at the
24 time.

25 So it's not necessary to have written records in

1 order to obtain that information.

2 LADY SMITH: Yes.

3 MR MACAULAY: There was no mechanism in play to report
4 abuse.

5 So, my Lady, to conclude, this has been
6 a significant case study and it is apparent from the
7 submissions made by providers that there is
8 an acknowledgement of widespread sexual, physical and
9 emotional abuse, and your Ladyship may have little
10 difficulty in concluding that the abusive regimes
11 identified are clear evidence of serious systemic
12 failures.

13 So, my Lady, those are my submissions.

14 LADY SMITH: Thank you very much, Mr MacAulay.

15 Now, I'm about to turn to those who represent
16 parties who had leave to appear in this phase, but just
17 before I start that, could I ask each of you who is
18 presenting their submissions to me to introduce
19 yourselves.

20 The reason I'm asking that is you can see how many
21 of you there are here, and that will be of great
22 assistance to the stenographers, if they hear who you
23 are and who you represent, without having to dot back
24 and forth to the written schedule that, of course, we
25 have given them. But it would help them, and they've

1 got a lot of work ahead today, if I could do that.

2 So I turn firstly to the representation for INCAS
3 and that's Ms McCall.

4 Submissions from Ms McCall

5 MS MCCALL: Thank you, my Lady. I am Shelagh McCall KC,
6 representing INCAS.

7 My Lady, on Day 596 of this Inquiry, the current
8 Chief Social Work Officer of Perth & Kinross Council
9 told the Inquiry:

10 'I think one of the most heartbreaking statements
11 for a social worker to hear is when parents in
12 particular say, "We entrusted our children into your
13 care and actually they've come out of this care system
14 more damaged than when they went in", and I think that's
15 a real indictment, I suppose, in terms of the care
16 system.'

17 That indictment has once again been made out by this
18 case study. The Inquiry has heard that children
19 suffered physical, sexual, emotional and psychological
20 abuse across a range of institutions.

21 In the course of the evidence, comments have been
22 made about the prevailing culture of the past and the
23 risk of judging an earlier era by today's standards and
24 values. And no doubt some of the evidence was
25 reminiscent of a time when physical chastisement of

1 children was common at home, in school and in care
2 settings. There can be little argument, I suspect, that
3 there was a culture of casual violence towards children
4 in society, but the accounts heard go far beyond what
5 could ever have been considered reasonable.

6 The Inquiry has heard of children being beaten with
7 fists and feet, with any implement that came to hand;
8 canes, belts, slippers, rulers, wooden brushes, rods.
9 Children were beaten to such a degree that resulted in
10 bleeding and bruising.

11 Restraint was often used as a measure of first and
12 not last resort. Some children were seen to lose
13 consciousness as a result of staff piling on like a mob.

14 Across many of the institutions considered, children
15 were force-fed, sometimes to the point of vomiting.
16 They would be made to eat food from a bowl on the floor.
17 The evidence about being forced to eat from the floor
18 illustrated a broader picture; namely that staff at many
19 institutions routinely indulged in practices which were
20 designed to humiliate and degrade children.

21 There could be no purpose other than degradation to
22 the practice of belting, caning or slipping children
23 or their bare bottom.

24 At multiple institutions the Inquiry heard that
25 children had carbolic soap forced into their mouths and

1 were punished with cold baths.

2 Perhaps one of the most striking examples in this
3 case study has been in the context of bed-wetting.
4 Children were forced to do a walk of shame with their
5 soiled sheets. Across many institutions, staff rubbed
6 children's faces in wet sheets. Others were paraded in
7 nappies, wrapped in their sheets and forced to sleep in
8 soiled bed linen.

9 The level of humiliation inflicted for something
10 that children did without awareness is shocking. The
11 distress of witnesses was still evident.

12 It's not proposed to describe here the sexual abuse
13 which has been recounted by witnesses. Suffice to say,
14 in many instances it was of the most serious kind. What
15 was striking in the evidence was the frequent occurrence
16 of what we would now recognise as grooming, trafficking
17 and sexual exploitation.

18 Children were sexually abused by staff members, by
19 visitors to the homes invited in by those in charge, and
20 by other residents. But they were also sexually abused
21 outside of the homes, by members of the local community,
22 by people associated with the church, by those for whom
23 children worked in a part-time job.

24 It seemed that many of these perpetrators were well
25 known among the children. Some were even given

1 nicknames revealing the sort of character the children
2 thought they were. It beggars belief that adults
3 involved in their care did not at times have at least
4 some inkling of what was occurring.

5 A question remains as to the extent to which there
6 were networks operating as opposed to lone perpetrators.
7 As James Ross recognised in relation to St Margaret's,
8 it was concerning that there was a number of men who
9 behaved in a particular way, and all of our knowledge
10 would tell us, that's fairly unusual.

11 Yet, the Inquiry's heard that a number of those who
12 appear to be the most prolific perpetrators hid behind
13 a veneer of respectability in the community. That was
14 certainly true of David Murphy and William Barrie.

15 The fact that some abusers were able to move from
16 one institution to another, even following complaints,
17 is unforgivable. It is symptomatic of a system that did
18 not care about children, that treated their allegations
19 as a problem that had to be got rid of, rather than
20 treating them as human beings suffering at the hands of
21 the people entrusted to care for them.

22 The Inquiry's heard numerous examples of failures in
23 oversight and investigation. At Dunclutha there was
24 evidence that Matron must have been aware of physical
25 abuse by the housefather and that social workers may

1 have been told about it. The children did not feel
2 listened to and nothing happened.

3 As a consequence, when some went on to be sexually
4 abused, they simply decided not to tell anyone.

5 At Lagarie, a social worker received a complaint
6 from a child's mother that his back was black and blue.
7 Nothing appears to have been done.

8 Concerns were expressed by a range of professionals
9 about the care being provided by houseparents at Nimmo
10 House (sic) over a period of time. Clear concern was
11 noted in 1979 about two particular individuals. The
12 matter was escalated, but in the end nothing was done
13 and they remained in post for years.

14 Arun Singh recognised this was a whole-system
15 systemic failing, from recruitment of staff through to
16 inexcusable inaction by senior social work managers.

17 As the Inquiry's learned across multiple case
18 studies, the culture in many institutions and perhaps in
19 society more generally was that children in care were
20 maladjusted and not to be trusted.

21 LADY SMITH: And less important than children who were not
22 in care.

23 MS MCCALL: Precisely, my Lady.

24 LADY SMITH: Somehow of lesser worth and in some cases not
25 worthy of respect at all.

1 MS MCCALL: Correct, my Lady.

2 Things began to change in the late 1980s with better
3 child protection measures being introduced, but
4 regardless of the earlier culture, there were
5 allegations that always should have resulted in a record
6 being made and a proper investigation carried out. That
7 was particularly so for allegations of sexual abuse.

8 The abuse perpetrated by Peter Murray at Colonsay
9 House is illustrative of the catastrophic failures that
10 occurred. A complaint was made in 1977. According to
11 records, there was no police involvement. There was no
12 proper investigation albeit some people did give
13 statements. After internal discussions, Peter Murray
14 received a verbal warning for entering 'Scott's' bedroom
15 unaccompanied, contrary to standing instructions.

16 It was seen as an isolated incident. It was not.
17 Murray was a prolific abuser.

18 The system of inappropriate reliance on references
19 and the failure of the local authority to ensure that
20 staff working in children's homes were properly
21 qualified, experienced and suitable, was described as
22 'having opened the door to him'.

23 Murray was not unique in that respect. As
24 Kathleen Marshall noted, references were not followed up
25 and were also given in a rather cavalier manner. There

1 was some understanding that people would give good
2 references to get rid of bad people.

3 Marshall also described an attitude of disbelieving
4 children and being uncomfortable confronting adults.
5 She discussed the example of a child who left a note
6 alleging abuse by Gordon Knott. The child was
7 interviewed by Knott's wife and another and,
8 unsurprisingly, they retracted the allegation. No one
9 asked Knott if it was true.

10 The matter was discussed at a staff meeting, the
11 note recorded in a logbook, yet nothing was done to
12 properly investigate or involve an outside agency until
13 almost 20 years later.

14 Mr Knott later admitted abusing children in his care
15 and he told the Inquiry that at the time, he just didn't
16 feel he'd be caught.

17 More evidence of failure to investigate when
18 children spoke up was heard in relation to
19 St Margaret's. 'Jamie' described telling his social
20 worker what had happened to him. A letter from him to
21 the social worker disclosing the abuse is in evidence,
22 as is the reply. It was only once 'Jamie' had turned 18
23 that he felt safe to disclose because he was no longer
24 in the care system. That speaks volumes.

25 At the time of the letter, 1970, David Murphy was

1 still working at St Margaret's. The initial reply
2 appeared to criticise 'Jamie' for not reporting at the
3 time, claiming it would have been thoroughly
4 investigated. There was no basis for such a claim.
5 Rather, the contrary was probably true.

6 While it appears 'Jamie's' letter was passed to
7 police by Fife Council, 'Jamie' did not give a statement
8 in the end. There appeared to be a great deal of
9 miscommunication between the council, the police and
10 'Jamie', who felt he was being given the runaround.

11 No other form of action appears to have been taken
12 by the authorities at that time to investigate, or to
13 put measures in place to safeguard children still in
14 care. That was in spite of the social worker having
15 apparently involved the head of social work and other
16 senior figures.

17 'Dennis' told the Inquiry he also disclosed to his
18 social worker that he was being sexually abused by
19 Murphy. It was a contemporaneous report. It appears
20 that, rather than institute a proper investigation, the
21 social worker told Mr Murphy, who beat 'Dennis' as
22 a result. His social worker then asked him why he was
23 lying.

24 James Ross described this as inexcusable. He
25 explained:

1 'If there's one young person that's made
2 a disclosure and it's had that response, then we've
3 silenced the population of young people not to disclose
4 what was going to come down the road for them.'

5 It seems 'Jamie's' reticence to speak out whilst
6 still in care was warranted.

7 As is now known, in spite of 'Dennis's' and
8 'Jamie's' reports, Murphy continued working with
9 children and continued to perpetrate abuse.

10 Finally, after further allegations in 1973, when he
11 was suspended while a police investigation was carried
12 out, Murphy was moved away from the care of children.
13 That was not a vindication of the survivors. Rather,
14 a decision seems to have been taken by the senior social
15 work managers that the allegations were untrue, and as
16 the Inquiry knows, Murphy went on to work with children
17 again at Linwood Hall.

18 What's significant about the failure to deal
19 properly with allegations against Murphy is that when he
20 was finally prosecuted in 2001, he pled guilty. But by
21 then his abuse had spanned over 25 years and damaged
22 many lives.

23 I heard what your Ladyship had to say this morning
24 about the next phase and INCAS would welcome the focus
25 of that, because we invite your Ladyship to consider

1 discretely looking at how social work responded to
2 allegations or complaints, in terms of seeking to
3 safeguard children and prevent further abuse.

4 It appears there may be multiple reasons why nothing
5 was done in individual cases. It may be social workers
6 were disinterested or overworked. But it may also be
7 that policies and procedures prevented proper action,
8 particularly in the event of an apparent lack of
9 corroboration or a denial by the perpetrator. Or it may
10 be that pressure was brought to bear on those who wished
11 to pursue investigations.

12 As the Inquiry knows, complaints were not always
13 uncorroborated. The problem was that no one joined or
14 perhaps was permitted to join the dots. INCAS suggests
15 there has been a systemic failure in that regard,
16 characterised by seeking to place an obligation on
17 survivors to drive the process, as 'Jamie's' experience
18 demonstrates, rather than professionals taking
19 responsibility for protecting children.

20 The evidence across a number of case studies is
21 redolent of a lack of oversight, an absence of curiosity
22 and a desire to avoid having to deal with difficult and
23 complex situations. It requires further investigation.

24 At the end of this phase, INCAS remains concerned
25 that some organisations, particularly where they are

1 successor organisations, still fail to acknowledge the
2 occurrence of abuse in their institutions, because of
3 an absence of records or reports.

4 In this phase, one such example was Aberdeenshire
5 Council. In 2017, they denied any abuse had occurred.
6 In 2025, their response to the Inquiry was updated to
7 note that there were records of two allegations having
8 been reported to police.

9 However, absent a conviction, the council stated it
10 was not possible to definitively determine whether abuse
11 occurred.

12 The now Chief Social Work Officer gave evidence to
13 the Inquiry. He's only recently in post but he was
14 involved in preparing the revised 2025 response. Asked
15 by counsel whether he'd followed the evidence of the
16 former residents of Coblehaugh, he indicated he had not.
17 That may seem surprising. The reason for it was not
18 explored, but to be fair to the witness, he did state he
19 would wish to do so.

20 INCAS asks that the Inquiry go back to the witness
21 to ascertain Aberdeenshire's attitude in light of the
22 evidence of those former residents who described
23 physical, psychological and sexual abuse.

24 In an earlier phase, INCAS asked your Ladyship to
25 note that some local authorities had been reluctant to

1 tender personal apologies to individual survivors and
2 that this may have been the result of instructions from
3 insurers. INCAS noted that the message that sends to
4 survivors is that they continue not to be believed.

5 INCAS doesn't know whether that's what lies behind
6 this example of Aberdeenshire, but again INCAS invites
7 your Ladyship to give consideration to more detailed
8 exploration of the role of insurers in preventing
9 meaningful apologies.

10 INCAS has also on a number of occasions asked
11 your Ladyship to ask questions to ensure that where
12 organisations acknowledge abuse and apologise, their
13 words mean something outside of the Inquiry.
14 Regrettably, that's not always the case.

15 In this phase, the Sailors' Society provides a good
16 example of the problem. Following the BBC documentary
17 about Lagarie, their then chief executive told
18 Mark Daly:

19 'I can't change the past but I can make sure we do
20 things right now. I'm not going to play dirty with
21 this. I want to see a satisfactory outcome for them and
22 I'm committed to that.'

23 But what the Inquiry has seen, both back in the
24 2000s and later, after the documentary was broadcast in
25 2018, is a total failure to follow through on meaningful

1 accountability. It appears that in litigation in the
2 2000s, the Society took advantage of the time-bar rule,
3 viewed it as success, considered trying to recoup its
4 expenses from the Legal Aid Board, but decided not to
5 because of how that might look.

6 After the documentary, cases were again raised.
7 The Society chose to defend them, now arguing that
8 a fair hearing was impossible, that being the statutory
9 test to avoid the effect of the removal of the time-bar.

10 Since those actions were dismissed, it appears that
11 no survivor who raised a claim against the Society has
12 been offered any financial recompense and the Society in
13 the end chose not to participate in the Redress Scheme.

14 Why? Not because the Society apparently disputes
15 the allegations, but because they're unwilling to follow
16 through on their commitment to see a satisfactory
17 outcome for survivors for financial reasons.

18 INCAS is grateful to your Ladyship and to Mr Sheldon
19 for the dogged pursuit of this issue in questioning of
20 the witnesses from the Society who gave evidence about
21 the current position. Your Ladyship concluded their
22 examination by leaving them to consider further what,
23 concretely, the Society could do to meet its
24 responsibilities, as it says it wants to do, and INCAS
25 hopes your Ladyship will pursue an answer in due course.

1 Thank you.

2 LADY SMITH: Thank you very much.

3 Now, next I'm going to turn to the representation
4 for the Sailors' Society and that's Mr Duncan.
5 Mr Duncan, when you are ready.

6 Submissions from Mr Duncan

7 MR DUNCAN: Thank you, my Lady.

8 I am Alastair Duncan KC and I appear today on behalf
9 of the Sailors' Society.

10 Your Ladyship has a fairly lengthy written
11 submission from the Sailors' Society. Perhaps I should
12 begin by saying that I think it perhaps incorrectly
13 indicates that the Sailors' Society may be core
14 participants. They recognise that they have leave to
15 appear. They're grateful for that and they hope that
16 the submissions that have been made and are about to be
17 made will be of assistance to your Ladyship in --

18 LADY SMITH: They certainly have been, in preparation, thank
19 you, Mr Duncan.

20 MR DUNCAN: I'm grateful, my Lady.

21 Against that background and that indication, I'm not
22 proposing to read all of this out verbatim. I have
23 broken matters into four topics and I'll take them in
24 that order, but I will perhaps pass over one or two
25 parts just for the sake of making progress, but I would

1 adopt everything that's been said in the written
2 submission.

3 I begin with the topic of who are the
4 Sailors' Society. And, my Lady, I'm absolutely not
5 going to take up time on history, but suffice to say
6 the Society was formed in the aftermath of the
7 Napoleonic Wars. The name may have changed on a number
8 of occasions, but the objects have remained the same;
9 the advancement of the Christian religion, the
10 advancement of education and the relief of poverty and
11 distress among British foreign seamen and their
12 families' independence.

13 Your Ladyship had some more up-to-date explanations
14 of that in the evidence of Ms Baade and I refer to that
15 at paragraph 5 of the written submission. And I've also
16 brought us still further up to date because,
17 unsurprisingly, the events in the Middle East have led
18 to demands on the Society's assistance and resources.

19 But I move on, my Lady, maybe more to more germane
20 matters, and the first of those is the history of the
21 Society and Lagarie House.

22 What I've set out in the earlier part of the
23 submission is not irrelevant to that, because, as
24 Mr Sheldon observed in his questioning of Ms Baade and
25 Ms Warman, it is striking that the Society only ever

1 operated one establishment concerned with the care of
2 children. It had never done so before Lagarie and it
3 would never do so afterwards. We lack evidence as to
4 why that happened and we'll come back to that, and so as
5 Ms Warman said, really we are looking at suppositions.

6 I've provided your Ladyship with a quotation from
7 the written response from the Society and also at
8 paragraph 8, my Lady, we have at least a record
9 reporting comments made by Mr Kenneth Swan, who was
10 a member of the Society at the time, and he said, at the
11 time of the official opening, that:

12 'This is the latest development and expansion of
13 the Society's activities to meet a further need, this
14 home for children, the children of seafaring folk,
15 children who for one reason or another cannot for the
16 time being be properly cared for or looked after in
17 their own homes.'

18 Now, my Lady, as I say in the next paragraph, the
19 reasons for the home opening is one question, but the
20 more critical question is perhaps why the Society had
21 thought it had the competency to do this.

22 Again, we can only speculate what suppositions were
23 made. What we do know is that whatever interrogation of
24 that question took place at the time was inadequate.

25 It's interesting that Mr MacAulay this morning has

1 referenced the Clyde Report, which was something that
2 your Ladyship expressly raised in her questioning of
3 Ms Baade and Ms Warman and I reference that at
4 paragraph 10. And it is interesting and concerning that
5 notwithstanding the observations of the Clyde Report,
6 the Scottish Guild of the Society determined that it
7 should open a large institution for the residential care
8 of children.

9 And I say, my Lady, we don't know what good
10 intentions lay behind that, but we do know where they
11 led. As Ms Warman very frankly said:

12 'Today, the facts in front of us speak for
13 themselves.'

14 LADY SMITH: If it was done because at that time, just
15 post-war, there were strong concerns about children who
16 had lost parents, whose -- the buildings of their homes
17 may have been destroyed in Glasgow and Clydebank and so
18 on, the level of child need had risen pretty high and
19 they could try and address it.

20 MR DUNCAN: I think that's probably likely. I think we know
21 that there's an indication also of an absence of
22 anything else nearby; that may have been a feature too.

23 LADY SMITH: Yes.

24 MR DUNCAN: But where it led is not in doubt and the playing
25 of the BBC documentary, which Mr MacAulay has also

1 referenced, really sets that out, and I've said that
2 it's accepted that the power of that documentary is
3 undeniable, even for those of us who have watched it on
4 a number of occasions.

5 Mr Daly didn't say how the documentary got its
6 title, 'Suffer the Children', and it seems not unlikely
7 that that's a reference to scripture and I provide the
8 well-known reference. And in that context, the word
9 'suffer' has the meaning 'to let'. It is possible that
10 the decision to open Lagarie, the Society's
11 predecessor's hoped to let children have the qualities
12 that you would expect to find, indeed in any home, but
13 it is not in doubt that for many it did actually lead to
14 suffering.

15 That then leads me to the third topic, the history
16 of abuse of children who stayed in Lagarie House.

17 In their evidence to the Inquiry, Ms Baade and
18 Ms Warman repeated the acknowledgement made by
19 the Society in its written responses that children were
20 abused. Ms Baade said she was appalled by the awful
21 evidence of those -- of abuse that she had both read and
22 heard.

23 In what remains of the written record concerning
24 Lagarie, there are a few references to matters which
25 might have indicated something of the reality for

1 certain of the children. But again, repeating something
2 that Mr MacAulay has said, the voice of the children was
3 missing, and that was an observation that Ms Baade made.

4 I then go on to mention some of the evidence of the
5 individual applicants and perhaps it suffices to say
6 this in relation to that, my Lady: the applicants
7 describe a place of fear and terror, where children felt
8 scared all the time, where appalling abuse was meted out
9 to vulnerable children, and where even the most
10 fundamental elements of a happy childhood, for example,
11 the giving of birthday or Christmas presents, were
12 denied to the youngsters who found themselves in this
13 strange and scary place. It was a 'living hell', as one
14 former resident said.

15 So the question must be asked: how did the good
16 intentions of the Scottish Guild end up like this?

17 And in what follows in the written submission,
18 my Lady, I've suggested three aspects that might be
19 considered in that context. All of them have been
20 touched on by Mr MacAulay.

21 First, there is the question of recruitment. I'm at
22 paragraph 18, my Lady, of the script. There's the
23 question of recruitment: what steps were taken to ensure
24 that the right people with the right experience were
25 recruited. Reference is made to Anne Millar having been

1 a nurse and to the Barries having had previous
2 experience.

3 But the writer response from the Society goes on to
4 acknowledge the obvious truth, that whatever experience
5 these people had or were thought to have, they were
6 plainly the wrong people to hire, and Mr Sheldon brought
7 this out in his questioning of Ms Baade and Ms Warman.

8 The appointment, he said, of Anne Millar was an odd
9 choice. She had no experience, it seemed, of looking
10 after healthy children.

11 And as to Mr Barrie, there were clearly questions to
12 ask about who he -- about who or perhaps what he really
13 was.

14 I really -- I do apologise, I have got my phone
15 turned to 'vibrate'.

16 LADY SMITH: Thank you.

17 MR DUNCAN: I'm sorry about that.

18 I was at paragraph 19 of the written submission,
19 my Lady, and I had mentioned that there is clearly
20 a question about who or what Mr Barrie really was, and
21 as Mr Sheldon drew out in his questioning, there were
22 clues there.

23 LADY SMITH: Yes. And so far as Anne Millar was concerned,
24 it can't be assumed that because somebody is a qualified
25 nurse that they have the skills and talents to care for

1 children.

2 MR DUNCAN: It risks underplaying things to describe that
3 judgment as naive, but there's possibly an element of
4 that in there. I don't know.

5 We'll come back perhaps to that in a moment,
6 my Lady, when I come on to other topics.

7 If I move on to really the second issue to be
8 considered, which is at paragraph 20 to 21, which is the
9 absence of oversight. And this really sort of picks up,
10 I think, on the question your Ladyship has just asked.

11 At paragraph 22, what I've said is we're here to
12 talk about the Sailors' Society obviously and
13 Lagarie was the Society's home, the children were
14 the Society's responsibility. And on that matter
15 Ms Warman was clear in her evidence: there was very
16 limited oversight of the home and that systemic failure
17 was profound.

18 In a situation where insufficient thought --

19 LADY SMITH: Mr Duncan, you have just said Lagarie was the
20 Society's home. I think you mean the children's home.

21 MR DUNCAN: I absolutely mean that.

22 LADY SMITH: Yes.

23 MR DUNCAN: But I'm thinking about the role that the Society
24 had in relation to that home.

25 LADY SMITH: Yes, of course.

1 MR DUNCAN: The point being, my Lady, that although, as
2 Ms McCall has reminded us, there are certainly questions
3 to be asked of other agencies about their oversight.
4 I'm not here address that. It's the Society's
5 responsibility for the home that I address.

6 And I acknowledge, as Ms Warman and Ms Baade did,
7 that there was an absence of oversight here and it would
8 seem it just hadn't been properly thought about.

9 And I go on to say at paragraph 23, my Lady, that --
10 and this was something that Mr Daly drew out. It's not
11 as if the Society had nothing at all to do with the home
12 after it opened. Mr Daly referred to the
13 Chart & Compass article entitled 'The House That
14 Devotion Built' and I say that it bears little
15 resemblance to the descriptions of the children who
16 lived there.

17 Again, it's possible to see in how these assumptions
18 and perceptions may have been a feature, but to echo
19 something that Ms McCall said, the appearance of
20 respectability may also have been a feature of that.

21 I go on, my Lady, to say at paragraph 24 that beyond
22 these warm assessments of the home at the time, there
23 were, as was explored with the witnesses, examples of
24 incidents that demanded further scrutiny and
25 investigation. One of them has been mentioned already

1 this morning and I've referenced a number of others.

2 Paragraph 26 takes me to the third topic that
3 I would mention, and that's the very limited written
4 record, and on its own, it does make it difficult to
5 understand what was going on, but that consideration
6 only leads to this third question, which is the extent
7 of the retained record.

8 The Society has acknowledged on numerous occasions
9 that it retains a very limited record in relation to
10 Lagarie, and I absolutely understand how concerning that
11 will be for former residents.

12 I've set out, as the witnesses did, an explanation
13 of the investigations that were made to try and find out
14 what happened. But, my Lady, the bottom line on that is
15 that clearly not enough care has been taken in relation
16 to the preservation of these records and, as I describe
17 it in the written submission, these histories of
18 childhood. And the Society acknowledges that that is
19 highly unsatisfactory.

20 So, my Lady, I move to the final chapter, which is
21 entitled 'Reflections', and I start with something that
22 Ms Baade said during her evidence. She said -- this is
23 paragraph 28, my Lady, at page 10. She said:

24 'Lagarie is part of who the Society is today. Even
25 if it closed down all those years ago, it is something

1 that we are responsible for and we continue to be
2 responsible. So I think reading it as a cloud that will
3 now be lifted and removed is a little bit naive and
4 strange in my mind because it's not something that we
5 can ever remove from who we are.'

6 The Society would want to say three things about
7 that, my Lady.

8 The first is to acknowledge that over the years,
9 the Society's response to reports of abuse within
10 Lagarie has often fallen short of what was required.

11 The known history of subsequent reports of abuse is
12 set out in the Society's written response. There is
13 an unconfirmed suggestion of a report having been made
14 in 1960. There is then a letter to a local English
15 newspaper in 1990. The first confirmed direct
16 notification came in the early 2000s.

17 The Society acknowledges that its responses were
18 inadequate and Ms Baade and Ms Warman said as much in
19 their evidence.

20 LADY SMITH: When you say 'direct notification', you are
21 talking about a person who was a child at Lagarie.

22 MR DUNCAN: Who subsequently reported. Absolutely, my Lady.

23 LADY SMITH: Yes.

24 MR DUNCAN: And from the Society's perspective -- and

25 I underline that, I emphasise that, from the Society's

1 perspective -- the responses to reports of abuse
2 improved upon the appointment of a new chief executive
3 in 2013/2014. But -- and here's the reason for the
4 emphasis. But even from that perspective, the Society
5 would recognise that the approach that was taken at that
6 time still fell short in a number of respects, and again
7 this was recognised by Ms Baade and Ms Warman in their
8 evidence.

9 My Lady, inevitably and quite properly, these
10 reflections on past responses will direct attention to
11 consideration of the Society's present-day position, and
12 that leads to the second thing mentioned -- to be
13 mentioned: the Society's expression of sorrow for what
14 happened to the children in its care in Lagarie.

15 This was set out in its written response to the
16 Inquiry and in the opening submission that I made at the
17 beginning of this case study. It is repeated again
18 today. But what does 'sorry' mean to somebody who has
19 had a lifetime of sorrow? Potentially not very much.

20 Ms Baade recognised this in her evidence. To say
21 sorry is absolutely necessary, but for the children,
22 more is needed.

23 This leads to the third matter: beyond saying sorry,
24 what more can the Society do?

25 And this formed, your Ladyship will recall, and as

1 has already been alluded to today, this formed a key
2 part of the oral evidence given by Ms Baade and
3 Ms Warman.

4 They explained that the Society's reserves would
5 only permit it to make an available -- sorry, would only
6 permit it to make available an amount of money which,
7 sizeable as a lump sum, is likely to translate into
8 individual amounts that might well appear insulting,
9 given the seriousness of the circumstances.

10 LADY SMITH: I mean, one could quibble with that language,
11 Mr Duncan. They have a wide measure of discretion as to
12 how they use the money and I think it has to be heard as
13 them saying: this is, in our judgment and after
14 consideration, the way we are using the money at the
15 moment.

16 It's not that there is an outside force preventing
17 them using it in a different way.

18 MR DUNCAN: I --

19 LADY SMITH: I don't think that's what you're saying,
20 anyway, are you?

21 MR DUNCAN: No, well, I don't go as far as that.

22 I think, I mean, this was something that
23 your Ladyship canvassed with each of them.

24 LADY SMITH: I did, yes.

25 MR DUNCAN: And I think what your Ladyship said, there is

1 an extent to which what you are saying is the
2 responsibilities for today have to, you know, take
3 precedence over responsibilities for yesterday.

4 LADY SMITH: Well, that's what they're saying.

5 MR DUNCAN: And they both acknowledge that that was a valid
6 perception. And the fact of the matter is that they do
7 have those responsibilities, historic and present. And
8 although your Ladyship says there is no outside force
9 and is correct about that, they are a charity that is
10 required to act within their charitable objects and they
11 have to walk that particular line.

12 Now, that piece -- that section of evidence led to
13 an exchange, in particular in relation to the Redress
14 Scheme, and I know the Inquiry has sought further
15 evidence in relation to that. And my learned friend,
16 Ms McCall, has also engaged on that matter in her
17 written submission.

18 Your Ladyship, I hope, has seen the correspondence
19 in relation to it. The position was that the Society
20 wanted to participate in the Redress Scheme and they
21 engaged extensively with it, as was acknowledged by the
22 Scottish Government at the time.

23 It was unable -- the Society was unable to afford
24 the level of financial commitment that was being sought
25 and the scheme was not prepared to accept the figure

1 that the Society could afford.

2 So all of that was said in evidence, my Lady.

3 This exchange eventually led to an exchange between
4 your Ladyship and the witnesses and really consideration
5 of the question: well, if adequate financial
6 compensation cannot be paid, what else might be done?
7 And this is really, in a sense, Ms McCall's sign-off in
8 terms of her focus on the Sailors' Society.

9 My Lady, as your Ladyship encouraged them to do,
10 Ms Baade and Ms Warman have reflected on that question
11 and have taken forward some work in relation to it. And
12 in particular, the question of how, in a trauma-informed
13 way, resources would be -- could be used to deliver
14 support to survivor needs.

15 The Society already offers a number of forms of
16 support, for example counselling, but the question to be
17 considered is what more might be done and how that might
18 be delivered more effectively, and I can say to my Lady
19 that the proposals have been drawn up and have gone to
20 the trustees for their consideration.

21 Among those, it is possible, my Lady, that the
22 Society may need the advice of a suitably qualified
23 expert if this question is to be answered satisfactorily
24 and, perhaps really in an echo of learning from past
25 assumptions, that is something that is welcome.

1 But I do say this, my Lady: that in Ms Baade and
2 Ms Warman, the Society has at least got two individuals
3 who see the need to find a way forward, that tries to
4 meet the responsibilities of the past and of the
5 present.

6 Ms Baade quite properly said that Lagarie can never
7 be removed from who the Society is, and no doubt
8 implicit in that statement was the recognition that that
9 is exactly the position the children find themselves in.
10 Lagarie will always be part of them too. And that is
11 why they must and will work towards answering
12 your Ladyship's question of what more can be done.

13 LADY SMITH: When at the beginning of paragraph 35 you
14 write, and you said a moment ago, that it's possible
15 the Society will be looking for advice from a suitably
16 qualified expert, what type of expert are you referring
17 to?

18 MR DUNCAN: I think somebody who -- well, I think that's
19 a very difficult question to answer. I think they even
20 need to discuss that. But I think as a starting point
21 it needs to be somebody with expertise in the issue that
22 we're speaking about, which is assisting, in
23 a trauma-informed way, people who are -- who experienced
24 abuse, and they've identified one or two organisations
25 that might be of assistance in that context.

1 LADY SMITH: Thank you. That makes sense.

2 MR DUNCAN: My Lady, I don't think there's anything else,
3 unless your Ladyship has any further questions for me.

4 LADY SMITH: Am I to take it from what you've just been
5 addressing me on, with regard to the Sailors' Society's
6 handling the need, that they recognise to do something
7 more than say sorry -- or sorry is meaningless if it's
8 not backed up with action? What you were saying about
9 that is the way in which the Society would answer the
10 questions posed and comments made by Ms McCall just
11 towards the end of her submissions, particularly as
12 covered in paragraph 29, when she used the
13 Sailors' Society as a good example of the problem in
14 following through on dealing with the impact of this
15 harm that children have been caused.

16 It's a very long way of saying, have you got
17 anything more to say in response to something of
18 a gauntlet that Ms McCall threw down in the matters
19 covered in her paragraph 29?

20 MR DUNCAN: It was a fair gauntlet to throw down, my Lady.
21 I think all I can say in relation to that is there is
22 a process underway and the matter has gone to trustees
23 and it will be taken forward, is my understanding.

24 LADY SMITH: Okay. Thank you very much, Mr Duncan.
25 Well, I'm not going to invite the next batch of

1 submissions until after the morning break, so we'll take
2 the morning break now and I'll sit again after that.

3 Thank you very much.

4 You will all remember, I hope, that there is
5 a General Restriction Order that I've issued to protect
6 the identities of certain categories of people, and that
7 means their name can be used in the hearing room but
8 they're not to be referred to or identified as mentioned
9 in our evidence or in submissions outside this room.
10 And there was one such name this morning, it was a man
11 called RBP . His identity is protected.

12 Thank you.

13 (11.25 am)

14 (A short break)

15 (11.46 am)

16 LADY SMITH: Right, I'm now going to turn to the
17 representation for the Widowers' Children's Home Trust
18 and, Mr Macpherson, I think you're here to address me
19 for them.

20 Submissions from Mr Macpherson

21 MR MACPHERSON: Thank you, my Lady. My name is Ranald
22 Macpherson, and I appear again for the Widowers'
23 Children's Home Trust.

24 As your Ladyship is aware, the trust chairman, who
25 is here today, was present at the opening of the case

1 study and was present in person to hear all of the
2 evidence led regarding the trust. Mr Yellowlees gave
3 evidence at the Inquiry on 27 January this year.

4 As your Ladyship will recall, the trust is successor
5 to an organisation which ran a children's home in
6 Corstorphine in Edinburgh from the early part of the
7 20th century until 1980.

8 In their opening statement made on 10 December 2025,
9 the trustees told your Ladyship that they accepted that
10 there were children resident in the home who suffered
11 abuse.

12 None of the present trustees was involved in the
13 running of the home while it was open and their
14 acceptance was based on correspondence and meetings with
15 former residents and on consideration of such documents
16 that were available.

17 The trust has now had the benefit of reading the
18 evidence obtained by the Inquiry and, of course, hearing
19 the oral testimony of 'Isa' on 23 January this year.

20 Mr Yellowlees accepted in his evidence that the
21 trust's understanding of what had gone on in the home
22 had improved in recent years as more information came to
23 light, and the evidential hearing has added to that
24 understanding.

25 Your Ladyship may recall that at the conclusion of

1 Mr Yellowlees' evidence, he said that he had been
2 appalled at what he had heard. He acknowledged that
3 some children had suffered terrible abuse and that for
4 them it was not a home, as it was supposed to be. He
5 offered the trust's apology to all former residents who
6 had suffered in this way, and I can reiterate that
7 apology on behalf of the trust.

8 It is accepted that the abuse must have arisen due
9 to the conduct of individual members of staff at the
10 home and that there was a failure by the organisation to
11 prevent abuse.

12 The organisation had originally been founded to look
13 after the children of widowers, later expanded to
14 include other children whose parents were unable to look
15 after them.

16 By 1980, as a result of changes in local authority
17 policy, demand for places in the home had declined and
18 in February 1980 the home was closed. The assets of the
19 organisation were transferred to the present trust,
20 which came into being on 12 June 1980.

21 As has been the case with other organisations that
22 have appeared before the Inquiry, the present trust
23 exists only as a charitable body managing the funds that
24 were realised on the sale of the home, being the main
25 asset held by the predecessor organisation. It is not

1 involved in the care of children in any context.

2 Mr Yellowlees' own professional experience is in
3 financial management, rather than in residential care.

4 In the case of the Widowers' Children's Home Trust
5 in particular, its charitable purpose is not open-ended.
6 The trust's policy is to distribute 150 per cent of its
7 annual income. It follows that the fund will eventually
8 be exhausted and the trust wound up. That is
9 appropriate, because the trust's primary financial
10 obligation is intended to be to its former residents,
11 the last of whom left the home in 1980.

12 As your Ladyship may recall, the trust receives
13 applications from former residents for financial
14 assistance. These are considered on ground of need, and
15 over the years the trust has paid out sums, usually in
16 the hundreds or low thousands of pounds, but on
17 occasions significantly more, to former residents.

18 In relation to individual applicants, the trust
19 makes a modest annual payment -- sorry.

20 In addition to individual applications, the trust
21 makes a modest annual payment to all former residents
22 for whom it has contact details, at Christmas. The
23 amount is currently £220 and was last year paid to
24 26 former residents.

25 The trust accordingly keeps a register and

1 encourages correspondence from any former resident of
2 the home, and that has, of course, included
3 correspondence in relation to complaints of abuse and
4 claims for compensation.

5 In addition, an important element of the management
6 of trust funds is in donation to children's charities.
7 About £60,000 a year has been paid to these charities on
8 average over the last 10 years. In this way, the trust
9 considers that its funds benefit children at large while
10 allowing these charities to apply their own experience
11 and expertise in deciding how to use the money.

12 Evidence is entirely a matter for the Inquiry,
13 my Lady. The trust is not in a position to suggest any
14 discrete findings of fact in relation to the evidence
15 the Inquiry has received from former residents. The
16 trust has acknowledged that children at the home were
17 abused.

18 None of the trustees has any direct knowledge of the
19 home when it was in operation. The trust does not seek
20 to rely on evidence that might tend to suggest that
21 there was no real abuse in the home, such as the
22 affidavit of HRF. This affidavit was put to
23 Mr Yellowlees in the course of his examination. He
24 accepted that it may not be reliable.

25 The Inquiry may recall that 'Isa' said she and

1 others had remained in contact with HRF and that HRF had
2 attended their reunion, but it seemed that her feelings
3 toward HRF as a carer were equivocal at best.

4 In relation to the current and future actions of the
5 trust, my Lady, the trust continues to provide financial
6 assistance to former residents. By way of an example,
7 a recent application was made to a resident for
8 assistance in obtaining medical aids and the trust paid
9 just under £2,000 to that resident, who was able as
10 a consequence to repay a finance agreement.

11 In relation to residents who have complained about
12 abuse or made claims for compensation, the Inquiry is
13 aware that the trust has received correspondence from
14 solicitors acting on behalf of 12 of those. The trust
15 wrote to the two firms acting in February of this year
16 but has not received a response, aside from one letter
17 indicating that the firm no longer acted for the
18 particular claimant.

19 The trust acknowledges that some former residents
20 may benefit from counselling and the trust is willing to
21 offer financial assistance for this. It has contacted
22 the organisation Future Pathways and has been directed
23 to several providers of counselling services.
24 Unfortunately, it appears that there may be
25 a significant waiting period for residents who wish to

1 pursue this through the trust, but the trust intends to
2 explore other avenues in this regard.

3 LADY SMITH: When you say that the trust has contacted
4 Future Pathways, was that to get help from them in
5 identifying which counselling services may be of use to
6 former residents --

7 MR MACPHERSON: That's my --

8 LADY SMITH: -- as opposed to asking Future Pathways if they
9 would take these people on?

10 MR MACPHERSON: It's the former, in my understanding,
11 my Lady.

12 LADY SMITH: I thought that was what you meant. Thank you.

13 MR MACPHERSON: I'm obliged.

14 In its opening statement, the trust referred to the
15 Redress Scheme and I'm conscious, of course, that the
16 scheme is not something over which the Inquiry has any
17 remit. However, it is appropriate to mention the scheme
18 in this submission, because of the amount paid compared
19 to trust funds.

20 The trust so far has paid £267,000 into the scheme,
21 significantly more than it has distributed through other
22 means. The trust considers that this is an appropriate
23 use of funds, effectively allowing the scheme to take on
24 some of the burden of ensuring that assets held by the
25 former organisation will assist or compensate those who

1 have suffered childhood abuse in similar circumstances.

2 Lastly, my Lady, the trust intends to invite former
3 residents, in particular those with whom it has had
4 contact in the context of the Inquiry, to a meeting to
5 explain the distribution of its funds, its participation
6 in the Redress Scheme and its efforts to assist with
7 counselling.

8 Mr Yellowlees and the trust are keen to be as open
9 as they can with former residents about how it is hoped
10 things can move forward from here.

11 If I might just add another matter, my Lady.
12 I'm told just now that the Christmas letter that went
13 out to all former residents last year mentioned the
14 Redress Scheme and invited those residents who wished to
15 find out more about it to do so.

16 LADY SMITH: Is that the Christmas letter that also deals
17 with paying out the annual sum of, at the moment, £220?

18 MR MACPHERSON: Indeed. Exactly so, my Lady, yes.

19 LADY SMITH: Thank you.

20 MR MACPHERSON: In conclusion, my Lady, it remains for me to
21 state that the trust appreciates the importance of the
22 Inquiry's work and it is grateful for the opportunity to
23 take part in this part of the Inquiry and hopes that its
24 involvement might have been of some assistance.

25 LADY SMITH: Thank you very much, Mr Macpherson.

1 Now, I would like to turn to the representation for
2 Fife Council and that's Ms Thomson.

3 Ms Thomson, when you're ready. Thank you.

4 Submissions from Ms Thomson

5 MS THOMSON: Thank you, my Lady. Laura Thomson KC. I appear
6 on behalf of Fife Council.

7 My Lady, in the interests of keeping to time,
8 I would propose to read short the written submission
9 prepared on behalf of Fife Council.

10 LADY SMITH: Thank you.

11 MS THOMSON: Fife Council is grateful for the opportunity to
12 participate in this phase of the Inquiry's important
13 work. Fife Council remains committed to confronting the
14 failures of its past and to learning lessons in order to
15 better safeguard the children and young people in its
16 care in the future.

17 It welcomes the Inquiry's searching examination of
18 its past actions. However uncomfortable, however
19 critical your Ladyship's findings may be, Fife Council
20 does not shirk from the truth or from accountability.

21 Fife Council condemns child abuse in all its forms.
22 It welcomes the opportunity through this closing
23 submission to reiterate its acknowledgement and
24 acceptance that some of the children in its care were
25 abused by those responsible for their safety and

1 wellbeing, to apologise sincerely and without
2 reservation to those it failed to protect, and to
3 restate its commitment to learning lessons from the past
4 and to making positive change for the benefit of the
5 future children in local authority care.

6 It is trite now that Fife Council is a local
7 authority established under and in terms of the Local
8 Government (Scotland) Act 1994. It has statutory
9 responsibility for the provision of residential care for
10 children and young people within its local authority
11 area, as did its statutory predecessors.

12 St Margaret's Children's Home in Elie opened in
13 1955. Its purpose was to care for children and young
14 people who could not live with their birth parents and
15 who needed the care and protection of being looked after
16 by the local authority.

17 Up to 33 children of primary and secondary school
18 age were placed at St Margaret's at any one time. Many
19 had experienced poverty or neglect. In 1974, younger
20 children were moved to other local authority placements
21 and St Margaret's prioritised the care of, I quote,
22 'disturbed teenage children'.

23 LADY SMITH: That's a very unfortunate expression.

24 MS THOMSON: It is my Lady, yes.

25 St Margaret's closed in 1983, following a change of

1 policy to community-based residential care for children
2 in Fife.

3 My Lady, it is with deep shame and regret that Fife
4 Council acknowledges and accepts that many of the
5 children who were placed at St Margaret's suffered
6 physical, sexual or emotional abuse at the hands of
7 members of staff who exploited their positions of power
8 and trust.

9 It is with deep shame and regret that Fife Council
10 acknowledges and accepts that it failed to protect those
11 children who were entrusted to its care and that
12 systemic failures in safeguarding, together with the
13 culture within St Margaret's, combined to create
14 an environment in which abuse could thrive and abusers
15 could act with impunity in plain sight.

16 And it is with deep shame and regret that Fife
17 Council acknowledges and accepts that it failed to
18 listen to the children and young people who reported
19 abuse perpetrated at St Margaret's, failed to
20 investigate their complaints, failed to protect them and
21 other children from the risk of future harm, and failed
22 to offer them support.

23 The nature and extent of the abuse perpetrated at
24 St Margaret's is apparent from the convictions of David
25 Murphy and Trevor Francis, together with the evidence of

1 survivors.

2 My Lady, there can be no doubt that Mr Murphy was
3 both a predatory paedophile and a prolific offender. As
4 your Ladyship has heard, in 2001 he was indicted in the
5 High Court on 68 charges of child abuse. He pled guilty
6 to 30 of those charges. Of those, 16 were charges of
7 sodomy and 14 were charges of lewd and libidinous
8 practices and behaviour, involving 18 victims, aged
9 between 6 and 14. All but two of those offences were
10 committed whilst Mr Murphy was in a position of trust as
11 a housefather at St Margaret's.

12 As your Ladyship has heard, he was sentenced to
13 15 years' imprisonment. Both the sentencing judge and
14 the Appeal Court, which refused his appeal against
15 sentence, categorised his offending as being at the
16 extreme end of the scale.

17 Trevor Francis was convicted in 2017 of three
18 charges of assault and two charges of lewd and
19 libidinous practices and behaviour towards two girls at
20 St Margaret's between 1974 and 1975. He received
21 a nine-month prison sentence.

22 Turning to the evidence of survivors, my Lady, in
23 addition to the statements that were read in during the
24 Inquiry's hearings, the Inquiry heard in person from
25 'Jamie'. The evidence he gave, my Lady, was horrifying,

1 harrowing and utterly damning.

2 He spoke to spending a period of a few weeks at
3 St Margaret's when he was 6. He returned to
4 St Margaret's at the age of 7 and remained there until
5 shortly before his 14th birthday.

6 'Jamie' described the humiliation of being made to
7 walk from school to the children's home in soiled
8 clothing. He described Mr Murphy's determination that
9 he should follow his orders, and an occasion when the
10 same plate of uneaten food was brought to the table day
11 after day until it turned green with mould.

12 'Jamie' described Mr Murphy blocking foster
13 placements and isolating him from his foster sisters and
14 friends. He spoke to Mr Murphy's vicious and vindictive
15 nature, such as when he broke the news that the woman
16 who 'Jamie' believed to be his mother was not in fact
17 his mother and that she was dead and buried. In the
18 aftermath of this bereavement, when 'Jamie' was most
19 vulnerable, Mr Murphy's abuse escalated.

20 'Jamie' spoke to excessive punishment and sadistic
21 violence at the hands of Mr Murphy. On one occasion, he
22 was beaten to the point of losing consciousness. He
23 suffered broken ribs and his eyes were swollen shut as
24 a result of these assaults. He was banished to the
25 attic where he couldn't be seen by others and he did not

1 receive medical attention.

2 My Lady, in an especially harrowing chapter of his
3 evidence, 'Jamie' spoke to being taken out in a dinghy
4 by Mr Murphy. Mr Murphy pushed his head over the side
5 of the boat and held his head under water before raping
6 him. He said:

7 'I could kill you now and nobody would miss you.
8 There is nobody in this world who cares about you.'

9 He then pushed 'Jamie' into the Firth of Forth and
10 rode back to shore without him.

11 'Jamie' said in his evidence:

12 'Between him and the water, I thought I was dead.
13 It was cold. To this day I don't know how I got back,
14 but I did.'

15 'Jamie' gave evidence of life-long physical damage
16 caused by the abuse, for which he has undergone a number
17 of surgeries and because of which he has suffered the
18 retraumatisation of intimate medical examinations and
19 retelling his past. He suffers from depression and
20 panic attacks.

21 Turning, my Lady, to consider failings, deficiencies
22 and missed opportunities, Fife Council acknowledges and
23 accepts that it failed to protect the children and young
24 people in its care at St Margaret's.

25 Mr MacAulay referred to there being a number of

1 missed opportunities in relation to Mr Murphy and
2 a chronology of those missed opportunities serves to
3 illustrate wider systemic failings.

4 David Murphy was appointed as assistant housefather
5 at St Margaret's in 1959. He was soon promoted to
6 housefather and remained in post until his suspension in
7 1973.

8 As your Ladyship has heard, in the wake of
9 Mr Murphy's conviction, the then Chief Executive of Fife
10 Council appointed Black and Williams to carry out
11 an independent inquiry. The inquiry's Terms of
12 Reference included a review of the council's actions in
13 response to complaints of abuse and identifying lessons
14 to be learned.

15 Black and Williams note that there was no record of
16 the recruitment procedure in place at the time that
17 Mr Murphy was employed. They considered it likely that
18 the council would have required three references and
19 that those references would likely have been taken up,
20 but that little in the way of detailed information would
21 have been required.

22 Without knowing whether Mr Murphy's references were
23 in fact taken up by the council, the identity of his
24 referees and the extent of the information sought from
25 them, it's perhaps difficult to conclude that the

1 decision to appoint Mr Murphy was flawed. He was
2 a former police officer, had attained a college
3 qualification in residential childcare and had
4 experience of working in children's homes, all of which
5 would have made him appear a very suitable candidate for
6 the post.

7 My Lady, 'Dennis' was born in 1954 and was resident
8 at St Margaret's from the age of 8 until the age of 12.
9 He was sexually abused by Mr Murphy. He reported the
10 abuse to his social worker and Mr Miller, but instead of
11 listening, instead of being open to the possibility that
12 'Dennis' was telling the truth, instead of taking steps
13 to protect him and instigating a thorough investigation
14 of his complaint, Mr Miller disbelieved him and reported
15 him to Mr Murphy, who in turn punished him. He was
16 given the strap, privileges were withdrawn and he was
17 locked in a cold room.

18 This was a failing on the part of Mr Miller, for
19 whose failings Fife Council is responsible, and a missed
20 opportunity.

21 Mr Ross, Fife Council's Chief Social Work Officer,
22 described this failing as 'inexcusable'.

23 The Inquiry has heard that in 1970, 'Jamie' wrote to
24 his former social worker, Miss Walker, and told her that
25 he had been sexually abused by Mr Murphy. He explained

1 that he had been afraid to tell her before and that she
2 would not have believed him. In his letter he expressed
3 concern as to whether Mr Murphy still worked with
4 children. Miss Walker replied to 'Jamie's' letter in
5 the following terms:

6 'I can well understand your anxiety as a child being
7 in care and being frightened to discuss the matter you
8 refer to, but can reassure you that had you done so, the
9 situation would have been investigated very thoroughly
10 by either myself or Mr Savage, who was Children's
11 Officer before me.'

12 LADY SMITH: And that was in the face of him having spelled
13 out that he was afraid to say anything at an earlier
14 stage.

15 MS THOMSON: Yes, my Lady, and having expressed concern as
16 to whether Mr Murphy still had access to children.

17 LADY SMITH: Uh-huh.

18 MS THOMSON: In a telephone call, Miss Walker advised
19 'Jamie' that the police might become involved. 'Jamie'
20 made clear his willingness to return to Scotland for
21 interview. He visited a police station in London but
22 was told it was a matter for Fife Police. He received
23 no further contact from the police, north or south of
24 the border, or from the council.

25 Apart from reporting the matter to the police,

1 Miss Walker and Fife County Council took no action.
2 They did not investigate 'Jamie's' complaint. They did
3 not offer to support him. They did not consider whether
4 Mr Murphy presented a risk to the children in his care
5 or whether there was a need to safeguard them.

6 LADY SMITH: And that was in 1970.

7 MS THOMSON: Yes.

8 LADY SMITH: And Mr Murphy was still in post.

9 MS THOMSON: Not so very long ago, my Lady, and yes,
10 Mr Murphy was still in post, and these were the most
11 serious failings on the part of Miss Walker and Fife
12 County Council, for whose failings Fife Council is
13 responsible, and they represent another devastating
14 missed opportunity.

15 The Inquiry heard that in 1973, three years later,
16 four residents at St Margaret's alleged that they had
17 been sexually abused by Mr Murphy. Although he was
18 suspended from his post, there is no evidence that the
19 council took action to investigate the complaints made,
20 or that steps were taken to support the children who
21 made the complaints.

22 There is no evidence that the council revisited the
23 1970 allegations when the later complaints were made.
24 As such, they were viewed in isolation, rather than as
25 part of a pattern of behaviour. Nor is there evidence

1 that any consideration was given to whether other young
2 people at St Margaret's might also have been abused by
3 Mr Murphy.

4 Again, my Lady, these were the most serious failings
5 on the part of Fife County Council, for whose failings
6 Fife Council is responsible, and another missed
7 opportunity.

8 My Lady, I will pause here, if I may, to respond to
9 something said by Ms McCall in her address on behalf of
10 INCAS.

11 Ms McCall has invited your Ladyship to consider
12 a discrete phase of the Inquiry to look at how social
13 work responded to allegations or complaints in terms of
14 seeking to safeguard children and prevent further abuse.

15 It is, of course, a matter for your Ladyship whether
16 or not to accede to such a request and should she do so,
17 she can be assured of the council's continued
18 co-operation and assistance.

19 However, in my submission, counsel to the Inquiry
20 was most thorough in his exploration of Fife Council's
21 failings and Mr Ross, on behalf of the council, accepted
22 those failings without reservation. And I would
23 respectfully query whether a discrete case study would
24 provide the Inquiry with better evidence or more
25 evidence than it already has, at least in relation to

1 Fife Council.

2 For the avoidance of any doubt, my Lady, Fife
3 Council accepts Ms McCall's conclusion that there was
4 a systemic failure, characterised by seeking to place
5 an obligation on survivors to drive the process, rather
6 than professionals taking responsibility for protecting
7 children, and that the evidence is redolent of a lack of
8 oversight, an absence of curiosity and a desire to avoid
9 looking to deal with difficult and complex situations.

10 Returning to David Murphy, your Ladyship will recall
11 from evidence led during Phase 9 that following his
12 suspension, Mr Murphy was transferred to a role working
13 with elderly people, but that he later applied for the
14 position of housefather at Linwood Hall.

15 Although the senior manager who had interviewed him
16 and appointed him to his post was subsequently advised
17 of the earlier allegations, and strong concerns about
18 his appointment were expressed, his offer of employment
19 was not withdrawn, nor was his contact with children
20 supervised.

21 As your Ladyship knows, Mr Murphy went on to abuse
22 children at Linwood Hall.

23 LADY SMITH: Yes.

24 MS THOMSON: As was observed in Fife Council's closing
25 submission at the end of Phase 9, Mr Murphy's

1 appointment as housefather at Linwood Hall in 1976
2 illustrates both the absence of vetting procedures
3 within the council at that time and the devastating
4 consequences of their absence.

5 Mr Ross in his evidence said that if a rigorous
6 investigation had been carried out at this point in
7 time, Mr Murphy's employment at Linwood may well have
8 been terminated. He said:

9 'These serious matters need to be dealt with
10 rigorously, because the council's duty is to protect
11 children, not to protect its employees.'

12 My Lady, in November 1998, a former resident at
13 St Margaret's made a complaint, via his solicitor, of
14 abuse during his time at St Margaret's. Fife Council
15 did not obtain his statement and pass it to the police
16 until April 1999. Around that time, 'Jamie' also
17 provided a statement to the police.

18 It is acknowledged, with regret, that nothing
19 happened at pace, nothing was followed up and only the
20 threat of exposure by a journalist led to action.

21 There followed a press appeal for witnesses, a major
22 police investigation and, ultimately, Mr Murphy's
23 prosecution and conviction. In the aftermath of that
24 prosecution, Fife Council commissioned an internal audit
25 and the report by Black and Williams, each of which made

1 a number of recommendations. But for survivors of abuse
2 at St Margaret's, this was too little, too late.

3 My Lady, Fife Council extends its gratitude to the
4 survivors who gave written and oral evidence to the
5 Inquiry about their experience of abuse at
6 St Margaret's. The council commends their courage,
7 their strength and their generosity in sharing their
8 experiences in order that lessons may be learned.

9 Their evidence was harrowing and heartbreaking.
10 Those representatives of Fife Council who listened to
11 their evidence found that experience very difficult and
12 were deeply affected by it.

13 Fife Council want those survivors to know that the
14 council has listened to your experience, the council is
15 committed to learning from its mistakes and you have
16 made a difference to the future of children in care.

17 The council extends a sincere and unreserved apology
18 to all those who were abused whilst in its care at
19 St Margaret's and wishes to put on record its deep
20 regret for its shortcomings.

21 Actions speak louder than words and Fife Council
22 will be judged not only by reference to its past
23 failings, but also by the extent to which it is able to
24 evidence its commitment to change and improvement in
25 safeguarding practices in years to come.

1 My Lady, there is now greater knowledge and
2 understanding of child abuse, of the devastating impact
3 of abuse, and of the need to protect children from
4 abuse. Over the years there have been changes to
5 legislation, policy and practice. There has been
6 a change in culture. In particular, the culture of
7 disbelief that prevailed throughout the time that
8 St Margaret's was in operation has been replaced by
9 a willingness to listen with an open mind and
10 a commitment to thoroughly and robustly investigate
11 allegations of abuse.

12 In the years since Mr Murphy's prosecution, there
13 have been significant ongoing improvements within Fife
14 Council in relation to recruitment and vetting,
15 training, complaints processes and whistleblowing,
16 quality assurance and multi-agency working. These were
17 summarised in Fife Council's Phase 9 submission.

18 Since that submission was prepared in October of
19 last year, my Lady, Fife Council has introduced a number
20 of further initiatives in response to the evidence heard
21 before this Inquiry. These include the following:

22 Walking the floor. Fife Council recognises that
23 senior leaders must be visible and must have first-hand
24 experience both of the services delivered by social work
25 practitioners and how those services are received by

1 families. Following practice already set by Fife
2 Council's Chief Social Work Officer, senior leaders now
3 walk the floor within all care settings at a minimum of
4 every six months, in order to appraise the quality of
5 services being delivered.

6 Public protection. Fife Council has created the new
7 role of Public Protection Service Manager, whose remit
8 is to explore and implement fuller integration of Fife
9 Council's public protection functions into relevant
10 service areas in order to enhance safeguards for
11 vulnerable children and families.

12 Support for birth parents. Fife Council has
13 developed a service that offers support to mothers who
14 have lost the care of their children. This group of
15 service users has become an invaluable reference group
16 offering suggestions for improvement to relevant
17 services. As an example, the group developed child
18 protection order guidance to ensure that detailed plans
19 are in place to support mothers through the trauma of
20 the removal of a child at birth.

21 Child and family pledge. Since its most recent
22 provision of evidence to the Inquiry, Fife Council has
23 drafted an updated pledge to looked-after children which
24 sets out the high standards that families should expect
25 from the council's social work service. The pledge is

1 intended not just to set out the council's intention
2 towards looked-after children, but also its intention to
3 empower families to challenge the system, acting as
4 a benchmark against which the council's performance
5 might be appraised.

6 A promise to birth parents serves a similar purpose.

7 In conclusion, my Lady, the Inquiry has held up
8 a mirror to Fife Council's failure to protect children
9 placed at St Margaret's from abuse. As uncomfortable as
10 this may have been for the Fife Council of today,
11 listening to the evidence of survivors and confronting
12 its past mistakes are valuable prerequisites to ongoing
13 learning and commitment to meaningful change.

14 Should the Inquiry's recommendation be that further
15 changes should be made to policies, practices or
16 procedures in order to safeguard children and young
17 people entrusted to the council's care, your Ladyship
18 may be assured that those changes will be made.

19 Fife Council thanks the Inquiry for the opportunity
20 to participate in this phase of its work.

21 LADY SMITH: Thank you very much indeed, Ms Thomson.

22 The next representation I would like to turn to
23 please is for Renfrewshire Council and that's you,
24 Mr Young. So whenever you're ready.

25

1 block 2. As was referred to in the council's opening
2 submission, its understanding of how Gryffe operated was
3 limited, especially in regard to the years prior to its
4 inheriting responsibility for it in 1996.

5 Coming with that limited knowledge, the council does
6 not feel in a position to make any specific observations
7 on the evidence it heard, other than to note that those
8 giving testimony to abuse they suffered did so with true
9 dignity and bravery. Without the accounts of these
10 applicants, these events would largely remain
11 unrecorded. We therefore owe them all a debt for having
12 come forwards.

13 The council's Section 21 response regarding Gryffe,
14 the evidence given by its Chief Social Work Officer,
15 John Trainer, and some additional information that has
16 been submitted subsequently, my Lady, comprised the
17 extent of its institutional knowledge of events and the
18 systems surrounding them.

19 Beyond that, the council would highlight some
20 general themes which it has observed emerging regarding
21 Gryffe, in the hope that the Inquiry, with its far wider
22 lens, may find this helpful in identifying more
23 universal issues and learning.

24 However, to start with, my Lady, the council firstly
25 acknowledges, as it did in its evidence, that there were

1 incidents of abuse of children during the period that it
2 was in charge of Gryffe and prior to that. It
3 apologises unreservedly to anyone who suffered abuse at
4 Gryffe at any time for failing to protect them.

5 In common with this council's observations regarding
6 Phase 8 of the Inquiry, it appears that abuse reported
7 from Gryffe concerns principally physical abuse in the
8 form of excessive or otherwise inappropriate punishment,
9 accompanied by emotional abuse.

10 Failure to protect children from peer-on-peer abuse
11 also appears in the evidence and I note from
12 your Ladyship's opening comments today that this has
13 been noted already.

14 Sexual abuse also occurred at Gryffe on occasions.

15 Against that background, the council would observe
16 that inappropriate physical and emotional punishment and
17 also failures to address peer-on-peer abuse seem clearly
18 to be linked to the cultural environment prevailing both
19 within Gryffe at the relevant times and in society more
20 widely. Aspects of that culture also contributed to the
21 possibility for abuse to occur more generally and in
22 that sense, my Lady, the abuse may be described as
23 systemic.

24 The key features of the culture referred to include:
25 a prevalence of large-scale institutions for

1 accommodating children; misunderstanding or ignorance of
2 the role of trauma in children's behaviour; use of staff
3 who were not trained for a caring role, but rather
4 recruited from disciplinarian backgrounds; a philosophy
5 of care that prioritised discipline and reacted harshly
6 to indiscipline; lack of oversight within the
7 institution and externally, and disempowerment of
8 children in shaping their environment and in reporting
9 their concerns.

10 The council would suggest that the wider culture has
11 changed in the years leading up to and following local
12 government reorganisation in 1996 and that that has
13 helped in addressing these issues. Renfrewshire was not
14 alone as an authority in undertaking a review of the
15 institutions it inherited and in making changes, in
16 particular in making residential care homes smaller and
17 moving to a higher staff-to-children ratio.

18 Others of these changes have been traced in more
19 detail in this council's submission in Phase 8, so are
20 only sketched again here, and these would include:
21 recruitment and regulation of staff is now better tied
22 to formal professional standards. Caring staff require
23 to be SSSC registered and are appropriately trained,
24 including in trauma-informed practice. Care now aims to
25 promote positive relationships and children have access

1 to advocacy support and independent social workers.

2 Independent oversight generally is better. At
3 a national level the Care Inspectorate and SSSC provide
4 such oversight of the institutions and staff
5 respectively. Within Renfrewshire, as well as children
6 having their own social worker, independent
7 decision-makers review their cases regularly and
8 children's homes' managers have greater support and
9 oversight from an external management structure than
10 was the case historically.

11 Adding to the greater recognition of the child as
12 an individual, children are afforded greater privacy
13 within residential homes and will not share their
14 bedroom or, in most cases bathrooms, except with
15 siblings.

16 That leads me, my Lady, to two specific points that
17 the council has identified that perhaps have not been
18 covered in other submissions yet.

19 The issue of placement of sibling groups within this
20 type of accommodation is one area that has been
21 particularly raised in this phase. This council's
22 position is that practice has notably improved on that
23 point, especially in recent years. Siblings are now
24 accommodated together so far as is possible.

25 LADY SMITH: That qualification sounds a little loose,

1 Mr Young.

2 MR YOUNG: Yes, my Lady. I think it's maybe a recognition
3 of the fact that firstly it can be a situation that
4 sibling groups don't wish to be placed together.
5 I'm using the term 'sibling' here in its wider sense, so
6 it may include half-siblings who perhaps do not wish to
7 be placed with their half-siblings. And it is also the
8 case that some siblings may have particular needs that
9 mean that they really can't be placed with their
10 siblings and also receive the level of support that they
11 require.

12 LADY SMITH: Well, I can see what you are fastening on there
13 is the need to have regard to the children's own wishes.
14 Some half-siblings are very close, others are not.

15 MR YOUNG: Yes.

16 LADY SMITH: There may be particular needs that one of the
17 siblings has that can only be accommodated in one type
18 of accommodation that's not suitable for another one.
19 But the starting point must be: what do they say is
20 going to be right for them; what's going to work for
21 them. Mustn't it?

22 MR YOUNG: Yes, I think that's correct, my Lady. As
23 I've mentioned earlier in this submission, I think the
24 idea of the recognition of the child as an individual,
25 wishes that need to be respected, is much better

1 ingrained in practice than perhaps it was.

2 LADY SMITH: Because it's not just a question of looking at
3 the situation then, but realising that, looking ahead to
4 adulthood, the long-term impact on siblings who have
5 been separated and then feel they don't have family when
6 they're adults can be really quite profound and
7 scarring.

8 MR YOUNG: Yes, absolutely, my Lady.

9 So I was just remarking that siblings are now
10 accommodated together so far as possible and that
11 Renfrewshire Council has a stated policy of keeping
12 brothers and sisters together in any type of placement
13 and oversight of this policy is provided by annual
14 report to the relevant board of the council on such
15 placements requiring an explanation of those situations
16 where it has not been possible to fulfil.

17 So in other words, my Lady, there is independent
18 oversight -- independent from those directly dealing
19 with the children's case for those situations where it
20 is not possible, or believed not to be possible.

21 In terms of identifying areas for further
22 improvement, the issue that most clearly has come to
23 this council's attention is the question of registration
24 of staff who are not directly involved in caring for
25 children in residential accommodation, such as catering

1 staff and tradespersons.

2 Mr Trainer has submitted a letter supplementing his
3 evidence on this particular point.

4 LADY SMITH: Yes.

5 MR YOUNG: For Renfrewshire's part, it can confirm that all
6 domestic staff in its children's homes go through the
7 same process of disclosure and PVG registration as
8 carers do. Trade staff are also required to be PVG
9 registered, following the changes to that scheme that
10 came into force in 2025.

11 However, previously, those latter staff, trades
12 staff, were supervised while on the premises by someone
13 else who was registered.

14 It appears, however, that practice across the
15 country differs to some extent on this. Mr Trainer did
16 a perhaps informal bit of asking round of chief social
17 work officers and has provided this information in his
18 letter to the Inquiry. And it does appear that the
19 earlier approach to supervision of trade staff, rather
20 than formal PVG registration, is still taken in some
21 areas.

22 I would note, and this is not in the written
23 submission, my Lady, but this is an area of the law that
24 seems rather complicated and perhaps the changes to the
25 law are not as clear as might be wished in an area

1 that's obviously of some importance.

2 And it may be helpful for the Inquiry to offer its
3 observations in this -- in particular on correct
4 practice in this area, therefore.

5 LADY SMITH: Thank you.

6 MR YOUNG: Finally, my Lady, the council hopes that it has
7 been of assistance with this phase and looks forward to
8 the Inquiry's report in due course. Thank you.

9 LADY SMITH: Thank you.

10 Thank you very much, Mr Young.

11 Now, I'd like to turn to the representation for the
12 Salvation Army and that takes me to Ms Loosemore,
13 whenever you're ready.

14 Submissions from Ms Loosemore

15 MS LOOSEMORE: Thank you, my Lady. Sarah Loosemore,
16 representing the Salvation Army.

17 The Salvation Army wishes to begin its submissions
18 by reiterating its deep sadness and heartfelt sorrow to
19 the residents who were victims of any abuse during their
20 time at Redheugh.

21 The Salvation Army is grateful to those who have
22 come forward to the Inquiry to share their experiences,
23 and acknowledges and regrets that these experiences will
24 have caused pain and suffering to the victims and to
25 those close to them.

1 The Salvation Army offers its sincere apologies to
2 anyone who was harmed while residing at Redheugh.

3 The Salvation Army does not seek to challenge or
4 contradict the accounts of the former residents that are
5 before this Inquiry. The Salvation Army is deeply
6 saddened by the abuse that has come to light and is
7 committed to maintaining the highest standards of
8 safeguarding for any young people who continue to use
9 its services now and in the future.

10 My Lady, the written submission is formed of four
11 parts. In the interests of time, I'm not going to go
12 through all those parts orally.

13 LADY SMITH: That's fine.

14 MS LOOSEMORE: I'm content to just rely on the written
15 submissions in terms of the first part which sets out
16 just the sort of institutional history in terms of
17 Redheugh and the Salvation Army.

18 LADY SMITH: Thank you.

19 MS LOOSEMORE: The second part, which I will turn to, is the
20 scope of abuse at Redheugh, and your Ladyship has made
21 reference already to the fact that a letter has been
22 provided that updates the Salvation Army's understanding
23 of the scope of abuse.

24 LADY SMITH: Yes.

25 MS LOOSEMORE: And in light of all the evidence before the

1 Inquiry in relation to Redheugh, the Salvation Army
2 accepts that residents at Redheugh suffered abuse.

3 When the Salvation Army submitted its Part A to D
4 responses to the Inquiry, it was aware of the abuse
5 perpetrated by Stewart Burgess, who has already been
6 mentioned, because he has been the subject of criminal
7 convictions.

8 However, the evidence that's available to the
9 Inquiry, and which has now been made known to the
10 Salvation Army, has clearly demonstrated that abuse
11 occurred at Redheugh that went beyond that single
12 individual.

13 LADY SMITH: Yes.

14 MS LOOSEMORE: And in particular, the Salvation Army
15 acknowledges that there is evidence that residents
16 likely suffered sexual abuse by staff members that goes
17 beyond that perpetrated by Stewart Burgess. That there
18 is evidence that there was child-on-child violence or
19 bullying that was not adequately addressed by staff
20 members. That there is evidence that there was physical
21 abuse by staff members. And finally, that there is
22 evidence that there were certain interactions that took
23 place between residents and members of the local
24 community that were not addressed by staff.

25 The Salvation Army apologises again to all those who

1 suffered any form of abuse at Redheugh and accepts that
2 its systems failed to protect some of the children in
3 its care.

4 LADY SMITH: And those particular acknowledgements and
5 admissions, just for the record, are contained in Clyde
6 & Co's letter dated 15 June 2026, on behalf of the
7 Salvation Army and addressed to the Inquiry.

8 MS LOOSEMORE: Yes, thank you, my Lady.

9 LADY SMITH: Thank you.

10 MS LOOSEMORE: In addition to that, the Salvation Army also
11 wishes to apologise to the former residents of Redheugh
12 for the fact that most of the records related to their
13 time there have been lost and are not available for
14 review by the Inquiry or, indeed, any of the former
15 residents themselves.

16 And your Lady may recall that Dean Juster, in his
17 evidence on behalf of the Salvation Army, acknowledged
18 the upset that that can cause for people and apologised
19 on behalf of the Salvation Army.

20 And finally, the Salvation Army is especially
21 troubled by the fact that most of the young people who
22 were resident at Redheugh were already vulnerable. And
23 obviously it's not a feature unique to Redheugh, but
24 many of them had come from chaotic family backgrounds
25 and in particular with Redheugh, they were often sent to

1 Redheugh as part of a disposition by the
2 Children's Panel when they had committed criminal
3 offences.

4 LADY SMITH: Of course, the Children's Panel's jurisdiction
5 went and still goes beyond the commission of criminal
6 offences.

7 MS LOOSEMORE: Certainly.

8 LADY SMITH: And it could be for other reasons related to
9 the child: the child not going to school; there being
10 problems at home and so on. There could be a range of
11 difficulties in the child's life that the panel tries to
12 address and thinks that their lives are going to be
13 better, if they send them to a residential institution.

14 MS LOOSEMORE: Yes, certainly, my Lady, and there were
15 a range of background factors that led to individuals
16 being placed at Redheugh.

17 LADY SMITH: Yes.

18 MS LOOSEMORE: But the Salvation Army does acknowledge that
19 the abuse would have been particularly harmful to these
20 individuals, who already had significant pre-existing
21 challenges.

22 LADY SMITH: Yes.

23 MS LOOSEMORE: So, that brings me to the third section of
24 the submissions, which is the proposed finding in fact.
25 And the Salvation Army does not intend to make detailed

1 submissions with respect to findings of fact about the
2 abuse suffered by any particular former resident and is
3 content to rely on the Chair to make appropriate factual
4 findings in that regard. Obviously, the Inquiry is
5 aware that there are the criminal convictions of one
6 individual related to Redheugh.

7 But the Salvation Army does wish to take the
8 opportunity to comment on factual findings that
9 your Ladyship might make in relation to its role in the
10 prevention and response to abuse, and particularly in
11 relation to how matters were handled once complaints
12 were made against Stewart Burgess.

13 So that section of the written submission starts at
14 paragraph 12, my Lady.

15 The Salvation Army does not seek to be comprehensive
16 in discussing all of the evidence available about how
17 Redheugh approached prevention and response in its
18 decades of operation, but there were certain themes that
19 emerged from the evidence before the Inquiry that the
20 Salvation Army would like to address, starting with the
21 recruitment and qualifications and training of members
22 of staff. And this is obviously a theme that cuts
23 across many of the institutions that the Inquiry will
24 have looked at.

25 And it appears that in the case of Redheugh, staff

1 were often hired after relatively informal recruitment
2 and I have provided some examples in the submissions,
3 references in the evidence from former staff members.

4 By the 1980s, any lay staff who were running
5 residential homes in Scotland did have social work
6 qualifications; however, many more junior staff were
7 hired without such qualifications, and again there's
8 some references to the evidence in that regard.

9 One of the witnesses who provided a statement to the
10 Inquiry, 'Helena', lived at Redheugh as a child because
11 her parents worked there and she came back as
12 a houseparent at the age of 18 when her father was still
13 SNR of Redheugh. In her statement she was frank
14 about feeling that she was too young and did not have
15 the preparation, training or experience to carry out her
16 role as houseparent.

17 Although there were no legal requirements, as
18 I understand it, at that time for all staff to have
19 particular qualifications, the Salvation Army recognises
20 that by hiring staff without appropriate qualifications
21 and experience to work with vulnerable and sometimes
22 challenging young people, that is not consistent with
23 ensuring that their needs, that the residents' needs
24 were being met both in general terms and also
25 specifically in relation to child protection.

1 The Salvation Army's hiring practices have changed
2 considerably since the closure of Redheugh and
3 I believe, my Lady, there's a number of policies that
4 have been provided to the Inquiry.

5 LADY SMITH: Yes, we have them. Thank you.

6 MS LOOSEMORE: And I think that the recruitment policy is
7 one of them.

8 Under the current policy, for roles that involve
9 working with vulnerable people, the candidates are
10 required to provide references that cover the previous
11 three-year period of their employment, and the policy
12 does cover both external and internal candidates who are
13 applying for new roles within the organisation.

14 And the Salvation Army's current safeguarding
15 policy, which should also have been provided to the
16 Inquiry, requires that an appropriate criminal record
17 background check be made for relevant roles, which is
18 a defined term in the legislation that now governs the
19 area.

20 LADY SMITH: Yes. I take it you're referring to
21 paragraph 14 of your recruitment policy? If you don't
22 have it in front of you, don't worry. I think I've got
23 the right one.

24 MS LOOSEMORE: I trust that your Ladyship probably has
25 identified the correct paragraph. Thank you.

1 LADY SMITH: Thank you.

2 MS LOOSEMORE: So, the policy obviously covers all the
3 different jurisdictions in the UK. So in Scotland, the
4 background check is processed through Disclosure
5 Scotland and any staff, volunteers or officers in
6 regulated work must be registered with the
7 Protection of Vulnerable Groups scheme, which is the
8 PVG.

9 LADY SMITH: Yes.

10 MS LOOSEMORE: So that's the submission in terms of staffing
11 issues.

12 LADY SMITH: Thank you.

13 MS LOOSEMORE: And beyond that, obviously, the Salvation
14 Army has accepted that there were systemic failures that
15 led to a failure to protect the children in its care.
16 And the fact that Stewart Burgess was able to sexually
17 abuse a number of residents over a period of years is
18 obviously indicative of systemic failure.

19 Now, given the lack of records, it's difficult to
20 comment on systemic failure in a comprehensive way, but
21 certainly there are examples that came out in the
22 evidence before your Ladyship.

23 In the written submissions, I've provided a couple
24 of examples of what I would class as inadequate
25 supervision, and I won't read those out in detail.

1 Then at paragraph 20, the submission deals with the
2 Salvation Army's response specifically to allegations of
3 abuse.

4 And in the Part A to D responses that have been
5 provided to the Inquiry, the Salvation Army set out its
6 understanding of what had happened with respect to
7 Stewart Burgess, based on the information it had at the
8 time.

9 And actually, because of the evidence that the
10 Inquiry's been able to gather, a slightly fuller picture
11 has emerged, although there are still some gaps,
12 I think, in our understanding of exactly what happened
13 there.

14 But what the Salvation Army would like to
15 acknowledge, based on the records that it has now seen,
16 is that there was a delay in reporting this matter to
17 the police between 24 April 1992, which was the date
18 when a former resident first advised the Salvation Army
19 that he had been abused by Mr Burgess during his time at
20 Redheugh, and then 27 July 1992, which is when the
21 Salvation Army did report the matter to the police.

22 And in the interim, it appears that the Salvation
23 Army did carry out its own investigations into the
24 matter. There were -- your Ladyship may recall that
25 there was the allegation by the former resident and then

1 that was closely followed by an allegation from
2 a current resident, and that current resident initially
3 disclosed to a staff member named Isobel McGookin. And
4 her initial response, according to the documentary
5 evidence that we have, to the disclosure, was to suggest
6 that it might be Mr Burgess playing. When that
7 suggestion was rejected by the resident, Mrs McGookin's
8 advice was that he should forcefully tell Mr Burgess to
9 stop his actions if the behaviour continued.

10 The Salvation Army accepts that this was clearly
11 inappropriate advice to give to a young person who has
12 just disclosed sexual abuse by a staff member.

13 It also appears from the records that we have that
14 Mr Burgess was not immediately suspended from work when
15 the allegation was made in April. Salvation Army
16 members, it appears, met with the former resident, who
17 had made the initial complaint, twice, on 12 May and
18 then on 11 June, before the step of suspension was
19 taken. And, of course, by June there had been the
20 second allegation made by a current resident.

21 So it was only after all of that, on 22 June 1992,
22 that Mr Burgess was suspended.

23 Dean Juster made clear in his evidence on behalf of
24 the Salvation Army that that is an unacceptable way to
25 approach things and it's not how matters would be

1 handled today.

2 The Salvation Army's first notification to the local
3 authority, which at that time was Strathclyde, was on
4 23 June 1992, the day after Mr Burgess's suspension.

5 Strathclyde ultimately decided not to involve
6 themselves in the matter, but did recommend to the
7 Salvation Army that they notify police, and that
8 notification was made, as I say, on 27 July 1992.

9 In the meantime, representatives of the Salvation
10 Army had met with Mr Burgess on 13 July to ask him about
11 the allegations.

12 Now, any failures on the part of the local authority
13 or the police are not really for the Salvation Army to
14 comment on, but what the Salvation Army wishes to make
15 clear is that the failure to act immediately following
16 that first report of sexual abuse by Mr Burgess, to both
17 suspend Mr Burgess and notify the police, is clearly
18 unacceptable.

19 LADY SMITH: Yes, and there are two problems that arise
20 there. One is that it's a failure to respond
21 appropriately to somebody who has reported abuse, and at
22 the same time, with a member of staff who remains in
23 post, it's a failure to act appropriately to protect
24 children who remain in the establishment.

25 MS LOOSEMORE: Yes, absolutely, my Lady.

1 There's also some evidence that HDD, who -- I think
2 by that point, that individual had been permitted to
3 a position that was higher than Redheugh itself. He, on
4 behalf of the Salvation Army, had some motivation to
5 ensure that the reputation of the organisation was
6 protected, and the Salvation Army wishes to make clear
7 that it is appalled by the idea that the good name of
8 the Army could take precedence over the protection and
9 safety of the young people in its care.

10 LADY SMITH: Indeed, and prioritising reputation is
11 a temptation to organisations and I have seen that
12 happening all too often, but it's a trap they must not
13 let themselves fall into. Simple as that.

14 MS LOOSEMORE: Yes, I quite agree, my Lady, and I think
15 Mr Juster said as much also in his evidence. I don't
16 know if your Ladyship recalls, there were the list of
17 considerations and I think the protection of children
18 was at the bottom and Mr Juster said this should be
19 completely inverted.

20 LADY SMITH: Yes, should be at the top, yes.

21 MS LOOSEMORE: Now, the other disturbing aspect of the
22 investigation into Stewart Burgess that has been
23 identified in the evidence relates to concerns that were
24 apparently raised before the 1992 disclosures. And in
25 the course of investigating those matters, on 22 June

1 1992, HDD spoke with Mrs McGookin, who was the person
2 who had first received the complaint from the
3 then-current resident. And she indicated at that point
4 to HDD that she had observed some troubling behaviour by
5 Stewart Burgess years before, and she also spoke of
6 a complaint that had been made by a different resident
7 four years earlier, so that would be 1988, which was
8 dropped.

9 The details of exactly what happened to that
10 complaint I believe are not known. But it appears not
11 to have resulted in any action at the time on the part
12 of the Salvation Army and the Salvation Army does wish
13 to acknowledge that that represents a missed opportunity
14 to address the abuse perpetrated by Mr Burgess.

15 Now, the precise timing and circumstances of
16 Mr Burgess leaving his employment with Redheugh are
17 difficult to identify because of the gaps in the
18 records, but it does appear that he was at some point,
19 likely in the autumn of 1992, either made redundant or
20 dismissed.

21 It was his evidence that he was informed that he had
22 been made redundant at some point after the suspension,
23 and he's told your Ladyship in evidence that he had
24 received a redundancy payment along with the letter,
25 although there's no documentary evidence available on

1 that. And the available evidence about what happened
2 between that initial disclosure, the suspension, and
3 then the ultimate redundancy or dismissal is incomplete.

4 It is clear that the Salvation Army did speak with
5 certain witnesses and did speak to Mr Burgess himself on
6 13 July -- and there's a typo there in the written
7 submissions, it should be 1992, my Lady.

8 However, there's no available evidence of any formal
9 disciplinary hearing taking place and no record of any
10 outcome from such a hearing, and that raises questions,
11 which were explored with Mr Juster in his evidence,
12 about what would have happened had Mr Burgess tried to
13 gain employment at a different facility after he was
14 made redundant.

15 Now, there's no evidence that he actually did do
16 that and so it would be a matter of speculation as to
17 what the Salvation Army would have done in those
18 circumstances back in the 1990s, but what Dean Juster
19 made clear in his evidence and the addendum letter,
20 which has also been sent to the Inquiry --

21 LADY SMITH: Yes, yes.

22 MS LOOSEMORE: -- is that were this situation to arise
23 today, the PVG scheme would operate to ensure that the
24 existence of these allegations was made known to any
25 potential employers.

1 And in fact, my Lady, in the internal safeguarding
2 policy of the Salvation Army, it specifically requires
3 that even if a staff member resigns, retires or changes
4 roles following a safeguarding incident, the inquiry
5 into the incident must conclude and a decision must be
6 made on the action that would have been taken, were the
7 staff member still employed.

8 LADY SMITH: Thank you.

9 MS LOOSEMORE: And the case must then be discussed with the
10 safeguarding department and, where appropriate, it will
11 be referred to the barring agency.

12 LADY SMITH: Thank you.

13 MS LOOSEMORE: So certainly their internal policy quite
14 clearly addresses that situation if it were to happen
15 today.

16 LADY SMITH: Thank you.

17 MS LOOSEMORE: And I think I've already said, but the
18 Salvation Army accepts that it clearly fell short in its
19 response to the allegations that were made about
20 Stewart Burgess in the spring of 1992, and for that, it
21 apologises.

22 The Salvation Army did take steps, albeit belatedly,
23 to suspend Mr Burgess and notify the local authority and
24 then the police, and the Salvation Army did also
25 co-operate with police investigations into

1 Stewart Burgess in 2004 and 2008 and 2018.

2 My Lady, I'm conscious of the time. There is
3 another example of a substandard response to --

4 LADY SMITH: Yes.

5 MS LOOSEMORE: -- an allegation being made to staff, but
6 I won't read that one out.

7 LADY SMITH: Yes. It's in your written submissions. Thank
8 you for that.

9 MS LOOSEMORE: Yes, I just rely on the written submission
10 for that, and I'll also rely on the written submission
11 in terms of the material under the heading, 'Other
12 experiences at Redheugh'.

13 LADY SMITH: Yes.

14 MS LOOSEMORE: And that takes me to the final part of the
15 submission, which starts at paragraph 41, which is about
16 safeguarding in the present.

17 Now, although Redheugh has closed and the Salvation
18 Army does not offer any residential care services to
19 children in Scotland, it does still offer certain other
20 services to children and I believe, my Lady, this was
21 something that your Ladyship had asked about in the
22 opening submission. And the Salvation Army, I think
23 this was set out in a letter to the Inquiry, but the
24 Salvation Army is present in over 60 locations in
25 Scotland and their engagement with children includes

1 various church-based activities, including youth clubs,
2 residential summer schools and adventure camps, music
3 groups and music tuition.

4 So there's obviously still a need for robust
5 safeguarding procedures.

6 LADY SMITH: Yes, and a continuing provision of residential
7 care for the summer schools.

8 MS LOOSEMORE: Yes. There are some overnight -- exactly.

9 It doesn't offer any kind of full-time residency to
10 children, but there are these excursions that can take
11 place overnight.

12 The Salvation Army has very significantly developed
13 its safeguarding policies and procedures in the decades
14 since the closure of Redheugh. The Inquiry obviously
15 heard from Dean Juster, who is the Director of
16 Safeguarding for Children and Adult Protection, a role
17 which he has held, albeit under some different titles
18 over time, since 2001. And the Salvation Army suggests
19 to your Ladyship that it's very clear from his evidence
20 that he takes that role incredibly seriously and adopts
21 the view that the safeguarding and wellbeing of children
22 trumps all other concerns, and he was quite clear about
23 that in his evidence.

24 And then there are some paragraphs there setting out
25 some more specific things that have been put in place.

1 So there is now a safeguarding department that has been
2 established and a set of policies that are regularly
3 updated, reviewed and benchmarked against recognised
4 child protection standards, and the safeguarding policy
5 itself actually is currently under review.

6 In addition, there is mandated safeguarding training
7 for staff and volunteers working with children.

8 And I'll allow your Ladyship to read paragraph 44 in
9 the written submission. That sets out some more details
10 of the safeguarding framework that's in place.

11 LADY SMITH: Yes, that's very helpful. Thank you.

12 MS LOOSEMORE: And the other thing that the Salvation Army
13 wanted to draw to the Inquiry's attention is that as
14 part of its commitment to engaging with survivors, the
15 Salvation Army has met with one of the Stewart Burgess
16 complainers to apologise in person on behalf of the
17 Salvation Army, and a second in-person apology to
18 a former Redheugh resident is currently being arranged.

19 The Salvation Army recognises the importance of
20 providing a safe and respectful space for survivors to
21 be heard and remains committed to continued meaningful
22 engagement with any former resident who wants to come
23 forward.

24 LADY SMITH: Thank you.

25 MS LOOSEMORE: In conclusion, my Lady, the Salvation Army no

1 longer provides full-time residential services to
2 children in Scotland. However, they do still provide
3 residential services to adults, some of whom are
4 vulnerable, and non-residential services to children.

5 The Salvation Army sees participation in this
6 Inquiry as a valuable opportunity for further reflection
7 on its safeguarding policies and practice. The
8 Salvation Army will take the lessons learned during this
9 process and apply them to future service provision in
10 Scotland and, indeed, across the UK.

11 It is right and proper to acknowledge the past.
12 What happened is part of the history of the Salvation
13 Army and it is important that it not be forgotten, so
14 that we remain vigilant in the present.

15 Child welfare, including child protection, must
16 always be at the heart of any service provision to
17 children, particularly in residential settings.

18 The Salvation Army cannot change what happened in
19 the past, but it is committed to doing everything in its
20 power to prevent anything like this from occurring in
21 the future in any of the Salvation Army's provision of
22 services to children.

23 LADY SMITH: Thank you very much.

24 MS LOOSEMORE: My Lady, unless there are any questions,
25 those are the submissions.

1 LADY SMITH: Thank you very much. I have no further
2 questions.

3 We'll pause now for the lunch break and I'll sit
4 again at 2 o'clock. Thank you.

5 (12.58 pm)

6 (The luncheon adjournment)

7 (2.00 pm)

8 LADY SMITH: Good afternoon and welcome back.

9 I'd now like to turn to the closing submissions on
10 behalf of North Lanarkshire Council and I'm going to
11 invite Mr Batchelor to address me.

12 Submissions from Mr Batchelor

13 MR BATCHELOR: Thank you, my Lady. Duncan Batchelor for
14 North Lanarkshire Council.

15 My Lady, on behalf of North Lanarkshire Council,
16 I adopt the written submission which has been submitted
17 to the Inquiry. I don't intend to repeat that verbatim,
18 but intend just to go through it and emphasise what
19 I would see as some of the key points.

20 North Lanarkshire Council's involvement in this
21 phase of the Inquiry relates to Bellshill Children's
22 Home. That was a residential home for children which
23 operated from 1977 until 1998.

24 During the earlier years, 1977 to 1996, the home was
25 operated by Strathclyde Regional Council, and between

1 1996 and its closure in 1998, it was operated by
2 North Lanarkshire Council.

3 The council no longer retains full records in
4 relation to the home. There are, however, some records
5 available in relation to both former residents and some
6 other organisational records, which help cast light on
7 events, particularly in a period around the late 1980s
8 and early 1990s.

9 And one particularly important document which
10 I've highlighted, my Lady, is a critical inspection
11 report, which was an internal Strathclyde Regional
12 Council inspection report in relation to Bellshill from
13 1992.

14 And whilst that provides a helpful snapshot of how
15 the home was organised at the time, it's also understood
16 that largely that was how it operated during most of its
17 existence.

18 And at that point there were three separate groups
19 of children there, the home itself having capacity for
20 23 residents. The first group included young people
21 over the ages of 16 who were preparing for independence.
22 The second group involved emergency and unplanned
23 admissions to care and the third group included children
24 between 12 and 16 years of age where admission had been
25 planned.

1 It's understood in earlier years it may have
2 accommodated even more children than the 23, but
3 following the critical report in 1992, the number of
4 residents was reduced to 16.

5 The Inquiry had the benefit of hearing evidence from
6 Alison Gordon, Chief Social Work Officer of North
7 Lanarkshire Council, on Day 589. The Inquiry also heard
8 from former residents and former staff, including some
9 convicted of offences against children resident at
10 Bellshill.

11 What I would say as an overarching point in relation
12 to some of that evidence particularly, my Lady, is the
13 Inquiry may wish to treat the evidence of those
14 convicted of offences with a degree of caution.

15 In contrast, it's submitted that the evidence that
16 was heard from PVX was evidence upon which the Inquiry
17 can rely with some more confidence. He gave his
18 evidence in a straightforward and reflective manner, in
19 my submission.

20 North Lanarkshire Council wish to acknowledge that
21 abuse took place at Bellshill and to apologise for that,
22 my Lady. They acknowledge that children in care at
23 Bellshill were abused. They were subject to sexual
24 abuse, physical abuse, emotional abuse, bullying and
25 neglect.

1 It's also acknowledged, my Lady, that the systems in
2 place at Bellshill failed to protect children there from
3 being abused and that there were failures in response to
4 allegations of abuse.

5 North Lanarkshire Council apologises to any person
6 who suffered abuse as a child whilst in the care of the
7 council or its predecessor authorities.

8 In terms of findings in fact, I've set out on page 2
9 of the submission something of an overview, which
10 I think it's worth repeating.

11 Whilst some witnesses have reported some positive
12 experiences and positive relationships with some staff,
13 the general picture presented, both from the evidence
14 heard by the Inquiry and from the available documentary
15 evidence that we have, at least for this particular
16 critical period that we're looking at in the late 1980s
17 and early 1990s, was that Bellshill was not a safe and
18 stable environment for young people. Indeed, that
19 was the conclusion that was reached by the inspection
20 report carried out in 1992.

21 Notably, three former male members of staff have
22 been convicted of offences against children there
23 between 1985 and 1993, and a fourth member of staff
24 appears to have escaped criminal conviction due to
25 a lack of corroboration, the jury having considered him

1 to have actually committed the offence.

2 Witness PVX, who I have mentioned already, started
3 at Bellshill in July 1998 (sic) and he described on his
4 arrival a culture of chaos, with a running conflict
5 between staff and children. The home was understaffed
6 and the staff who were there were of mixed abilities and
7 attitudes.

8 One other really striking factor in my submission
9 from the evidence was in relation to the physical state
10 of the building. Witnesses spoke to smashed windows and
11 the physical environment really not being conducive to
12 child-centred care, and the 1992 inspection report,
13 my Lady, contains an extremely lengthy list of
14 outstanding repairs, physical repairs being required to
15 the fabric of the home.

16 I've alluded to the criminal convictions, my Lady.
17 The Inquiry may find as a matter of fact that three
18 former members of staff have been convicted of serious
19 sexual abuse of children at Bellshill. Those
20 individuals are Edward Doherty, an individual with the
21 pseudonym 'Jim', and Edward Stanton. And I would adopt
22 what's said in the written submission in relation to
23 those criminal convictions, my Lady.

24 It's accepted by the council that the matters which
25 have been the subject of criminal conviction will not be

1 the limit of the abuse which took place at the
2 establishment.

3 However, the fact that three separate male
4 employees, and probably a fourth, were able to commit
5 such serious offences against children at the
6 establishment does indicate a very concerning pattern
7 and is indicative that the safeguarding measures in
8 place at the time were inadequate.

9 I would adopt what is said in the written
10 submission, my Lady, in relation to the nature and
11 extent of other abuse, albeit that obviously our main
12 focus in most of the evidence was in relation to the
13 sexual abuse and the criminal convictions.

14 It does bear mentioning that the subject of bullying
15 was a recurring theme in relation to Bellshill. And
16 Alison Gordon's view based on her review of the evidence
17 was that bullying, particularly in this period from the
18 mid 1980s to the mid 1990s was systemic rather than
19 incidental, and it was enabled by there being
20 inconsistent staff responses and weak supervision.

21 And she acknowledged that the failure to intervene
22 created physical and emotional insecurity and compounded
23 children's trauma.

24 And she considered that the peer abuse, or the
25 prevalence of it, was also likely directly related to

1 the institution's size, its layout and its culture,
2 stating that the way Bellshill was operating at that
3 time would not be acceptable standards today.

4 And so whilst there's only a comparatively small
5 number of cases where abuse has been confirmed through
6 a formal process, the council acknowledges a much wider
7 pattern of complaints, allegations, disciplinary issues
8 and concerns, and it's likely that the true incidence of
9 abuse was greater than what's been formally proven or
10 recorded as abuse at the time.

11 Turning to systemic failures, the council accept
12 that there were widespread failures in safeguarding
13 systems at Bellshill, most strongly evidenced during the
14 period from the mid 1980s to the mid 1990s. There were
15 poor staffing models, inadequate training, weak
16 management oversight and a defensive organisational
17 culture.

18 And in the written submission, I've set out some of
19 the key themes, which have already been, I think,
20 touched upon by Mr MacAulay and also by several other
21 representatives this morning.

22 The model of care which was provided at Bellshill
23 was inherently unsuitable for vulnerable children.
24 There were too many children. The care was
25 institutional, rather than homely. It made it very

1 difficult to meet individual children's needs, and that
2 model itself contributed to unsafe conditions and
3 negative experiences for children.

4 I've already mentioned the organisation of the home
5 units. The multi-purpose nature of the establishment
6 compounded problems, particularly in managing behaviour
7 and safeguarding, and it's accepted by the council that
8 the way the home was organised led to confusion and
9 inconsistency, as well as a failure to provide stability
10 and safety.

11 Recruitment has also been a recurring theme. It's
12 clear from Bellshill that recruitment relied heavily on
13 temporary staff. Having a qualification in residential
14 childcare was desirable, but certainly not essential,
15 and it meant that many staff lacked relevant experience
16 and were unfamiliar with working with traumatised
17 children.

18 And the recruitment approach seems to have been
19 fairly cavalier. It was -- it seemed to be more
20 important that a shift was filled, rather than that
21 detailed consideration was given to the suitability of
22 the person who was filling the shift.

23 I've also mentioned there, my Lady, other recurring
24 themes which we've seen throughout the case study and
25 throughout other case studies, of a lack of training and

1 skills for staff and a lack of clear complaints
2 processes for children to make use of.

3 In relation to the response to allegations, it's
4 acknowledged there was a failure in response to
5 allegations of abuse. And one particular example was
6 candidly accepted by PVX in his evidence and that was
7 when, in 1990, a disclosure of abuse was made in
8 relation to a member of staff no longer working at the
9 home. An investigation was carried out in relation to
10 that and it was concluded that three girls had been
11 abused.

12 The girls themselves did not wish for the police to
13 be involved and, as a result, the decision was taken not
14 to inform the police. That was a decision made not just
15 by the staff at the home, but also endorsed by external
16 management at Strathclyde Regional Council at the time.

17 LADY SMITH: And that meant that other children to whom this
18 person could be exposed were not being protected.

19 MR BATCHELOR: Indeed. Not at the home, but potentially
20 elsewhere.

21 And the procedures at the time, my Lady, didn't
22 require the police to be informed, but it's accepted
23 that regardless of the individual's wishes, the police
24 should have been apprised of the disclosures and the
25 findings of that investigation, and PVX, I think, very

1 candidly accepted that in his evidence and it was
2 a matter of significant regret to him.

3 And as it happens, the individual in respect of whom
4 those disclosures were made did eventually land up being
5 convicted for those offences.

6 It's worth saying something further about the 1992
7 inspection report, my Lady. That report highlighted
8 many deficiencies, but the overriding conclusion of the
9 inspectors was that the establishment was not a safe and
10 suitable environment for vulnerable children and young
11 people.

12 It was highly critical and it identified serious
13 concerns about safety, living conditions, staff
14 incompetence and complaints and children's rights.

15 However, Strathclyde Regional Council management at
16 that time did not agree with the report's conclusions
17 that the establishment was not a safe and stable
18 environment, and there was a significant amount of
19 correspondence in relation to that, where really the
20 voice of the child and the experience of the children
21 seemed to get somewhat lost in what was
22 an organisational disagreement.

23 And the Inquiry may consider that the original
24 conclusions reached by that inspection report were, on
25 the evidence, justified. They may also -- you may also

1 consider that the management response was not obviously
2 child-centred.

3 And I think all of that correspondence around that
4 report perhaps underlines the importance of independent
5 regulation with enforcement powers, because it seemed to
6 be that essentially in the end what happened was that
7 the Head of Childcare at Strathclyde Regional Council
8 overruled the inspectors.

9 My Lady, we heard evidence about a fatal accident
10 inquiry in relation to the tragic death of William
11 McGovern, who was a 12-year-old child resident at
12 Bellshill, who took his own life in September 1992.

13 We had the benefit of a brief determination making
14 formal findings in relation to that death, but -- and
15 the sheriff in that determination found that any
16 suggestion that William's residence at Bellshill had
17 caused his death would be speculative.

18 I think what we can say now, looking back at that,
19 it's really not clear what evidence the sheriff had
20 available to him or whether he had the benefit of the
21 sight of the 1992 report.

22 However, there is certainly some evidence that
23 William may have been the victim of bullying at
24 Bellshill. There was a suggestion that he may have been
25 the victim of sexual abuse. However, in my submission,

1 there's insufficient evidence available for any finding
2 to be made in relation to that latter point.

3 I'd adopt what is said, my Lady, about modern day
4 residential care. At North Lanarkshire Council, there
5 is still residential provision. However, in keeping
6 with the general move in the sector, the residential
7 provision which is provided is now through much smaller
8 children's houses, and North Lanarkshire now have five
9 small purpose-built houses with a maximum of six
10 residents in each. So a significant reduction in the
11 number of children who are placed in each of the houses.

12 There have also been significant developments in
13 recruitment, training, supervision and reporting, much
14 clearer safeguarding guidance and inter-agency working
15 with the police and Care Inspectorate. And so I adopt
16 what is said at paragraphs 37 to 41, my Lady.

17 LADY SMITH: Thank you.

18 MR BATCHELOR: In conclusion, my Lady, North Lanarkshire
19 Council has found the evidence in relation to the
20 goings-on at Bellshill extremely harrowing and it wishes
21 to reiterate its apology to all of those abused there.
22 Not just for the abuse that they suffered, but also for
23 the organisational failures which allowed that to
24 happen.

25 LADY SMITH: Thank you very much, Mr Batchelor.

1 Now, next I'd like to hear from the representation
2 on behalf of Dumfries & Galloway Council. That's
3 Mr Thom, I think. When you're ready.

4 Submissions from Mr Thom

5 MR THOM: Thank you, my Lady. Ben Thom, legal
6 representative for Dumfries & Galloway Council.

7 My Lady, starting with submissions on the findings
8 in fact, in relation to Merkland's Children's Home there
9 was widespread serious physical and sexual abuse
10 perpetrated against residents of the home, ranging from
11 excessive corporal punishment to penetrative sexual
12 abuse.

13 Physical abuse sometimes left injuries such as
14 bruising and bleeding. Victims often suffered lasting
15 effects from the abuse they suffered, including
16 detrimental impact to their education, relationships,
17 mental health and overall outlook on life. That was
18 doubtless exacerbated by their early-life trauma, which
19 culminated in their initial placement in the home.

20 The officer-in-charge was in near complete control
21 of the home with other staff, excepting perhaps JDW
22 JDW, playing a far more limited support role
23 insofar as the children were concerned.

24 Peter Harley was able to influence appointment and
25 departure of staff within the home. Support staff were

1 neither suitably trained nor qualified. At night there
2 were usually no other staff working. Support staff
3 reported directly to Harley with no reporting line to
4 other council employees. There was a complete absence
5 of children's records in the home. All of that made it
6 easier for Harley to commit abuse undetected.

7 Peter Harley secured the role of officer-in-charge
8 from a place of relative inexperience, without thorough
9 vetting and without demonstrating formal qualifications
10 or training.

11 Abuse took place both within and outside the home,
12 such as on camping trips or trips in Harley's van.

13 Peter Harley was able to present an outward
14 impression of someone who cared for the children. He
15 was respected by authority figures within the community.
16 This diminished residents' confidence that they would be
17 believed should they report any abuse they suffered.

18 Within the home, Harley was authoritarian and feared
19 by the children.

20 Corporate governance and visibility was informal and
21 superficial in nature. There was a lack of formal
22 monitoring and supervision. The officer-in-charge dealt
23 directly with social workers and managers and there was
24 not a practice of social workers holding in-depth
25 discussion with the children.

1 There was no safe way for residents to disclose
2 abuse as it happened. Some residents disclosed abuse
3 they suffered to adults such as parents, psychiatrists
4 and social workers. Reports of abuse at the time were
5 generally not treated seriously, nor were they triaged
6 or escalated. Some children who made disclosures were
7 taken back to Merkland where abuse continued.

8 The isolation, lack of formal monitoring and
9 supervision, combined with the children's knowledge that
10 any complaints raised were not addressed appropriately,
11 created conditions for widespread abuse to take place.

12 Peter Harley's abuse was not afforded proper
13 recognition by the council until disclosures were made
14 to a criminal justice social worker in 1994, over
15 a decade after Merkland closed, which triggered
16 investigations, ultimately resulting in the first of
17 three successful prosecutions of Peter Harley.

18 My Lady, turning to the failures that are accepted
19 on the part of the council and its predecessors. The
20 council accepts there were failures by its predecessor
21 Dumfries & Galloway Regional Council, which ran Merkland
22 Children's Home from 1975 until the home's closure in
23 1982, and these include the following:

24 Warning signs and calls for help by the children
25 affected were either missed, ignored or not followed up

1 on. There were multiple instances of children telling
2 adults of the abuse they suffered contemporaneously. On
3 occasions, when social workers received the disclosure,
4 responses ranged from giving an assurance that the
5 matter would be looked into, to calling the child
6 a liar, to reporting the disclosure to Peter Harley and
7 the child being returned to his care. A lack of
8 triangulation or inquisitiveness led to these
9 disclosures remaining isolated until 1994.

10 Children who had worked up considerable courage to
11 raise concerns were branded as difficult or liars. They
12 were not listened to and placed back in danger and faced
13 reprisals from Peter Harley. This can only be viewed as
14 a missed opportunity to bring Peter Harley's actions to
15 a stop much sooner.

16 There was a lack of supervision and monitoring of
17 Merkland's operations and management. There was a lack
18 of formal governance procedures, or at least
19 insufficient effort by the council to require the formal
20 adoption or adherence to procedures, which would have
21 ensured a greater degree of monitoring, supervision,
22 visibility and proper record-keeping.

23 Harley operated with near complete autonomy, making
24 it more difficult for children's voices to be heard and
25 afforded due recognition. There was a skeletal staff,

1 with Harley and JDW in charge of the home, with few
2 others, and no trained social worker in residence or
3 staying overnight.

4 The superficial contact social workers who visited
5 the home had with the children seems to have too often
6 focused on outward presentation. There was repeated
7 reference to the uniform haircuts and distinctive
8 presentation of 'the Merkland boys', as they were known.
9 Witnesses spoke to the children being well fed and there
10 was a clear focus on a smart, clean appearance. On
11 a superficial level, the children might have appeared
12 healthy, but deeper probing by social workers ought to
13 have revealed major issues.

14 It appears that Merkland was almost out of sight and
15 out of mind to the wider authority. Moffat's
16 geographical location played a part in this, but
17 Merkland had a reputation as a home for 'bad children',
18 as they were seen at the time, and it was seen as
19 an establishment where bad behaviour could be addressed,
20 largely, it seems, through discipline, exercise and
21 regime.

22 Turning to whether failures have been addressed,
23 my Lady, by policy, practice, legislation.

24 There are now multiple layers of safeguarding in
25 place through practice, procedures, statutory guidance

1 and legislation, in particular. There is a stronger
2 workforce structure. Homes generally have multiple
3 staff on duty at all times, with a structured rota.
4 There is separation between roles such as managers, care
5 staff and social workers and the presence of residential
6 social workers now makes abuse far less likely to occur.

7 This in turn reduces the isolation of children,
8 prevents concentration of power in one individual and
9 improves oversight.

10 The current model for residential homes reflecting
11 national standards involves far smaller overall numbers
12 of children with a higher staff-to-children ratio. This
13 allows more time for staff in children's lives to pay
14 proper attention to them and their needs.

15 A legislative change is the introduction of
16 professional standards and qualifications of staff.
17 Staff must be properly qualified and trained and must
18 adhere to professional standards on an ongoing basis,
19 including receiving ongoing training. This reduces the
20 risk of unsuitable individuals entering the system,
21 combined with safer recruitment checks such as
22 disclosure and PVG schemes, which reduce the ability of
23 known perpetrators to repeat abuse or to undertake work
24 with children.

25 There is now improved access to children's advocacy.

1 This has arisen by a legislative change and, most
2 recently, the implementation of the UNCRC. There is
3 a strong emphasis on listening to the child's voice and
4 building safe professional relationships to foster trust
5 between the child and professionals caring for them.
6 This should make it easier for children to feel
7 comfortable raising concerns with adults and should
8 ensure that adults receiving disclosures have clear
9 obligations to escalate those.

10 Finally on this, my Lady, national and local child
11 protection measures now exist involving multiple
12 agencies with clear reporting mechanisms and structure.
13 All council staff at all levels receive mandatory
14 training on child protection to make them aware of their
15 obligations.

16 And I point out, my Lady, that there was a recent
17 inspection, from September 2025 to January 2026, which
18 highlighted positive caring relationships, as evidenced,
19 my Lady.

20 Turning briefly to whether there are any current
21 improvements or practices in place. My Lady will recall
22 that it was recognised in our Chief Social Work
23 Officer's evidence that safeguarding depends on
24 maintaining standards under pressure. The council has
25 adopted a staff recruitment and retention ethos of

1 'growing our own', which is intended to reduce caseload
2 pressures and improve continuity of care. This
3 recognises the challenges that Mr Morgan spoke to and
4 those are faced nationally with recruitment issues
5 particularly in rural parts of the country and the risk
6 created by overstretched staff.

7 The corporate strategic shift towards earlier
8 intervention requires safe and consistent high-quality
9 staffing. This approach seeks to develop clear career
10 pathways and progression routes to improved staff
11 retention.

12 My Lady, turning to themes that we've identified
13 from the phase as a whole, I have three and, in brief,
14 they are that firstly there was a pattern among
15 survivors of lessened educational outcomes. Witnesses
16 talked sometimes, and often actually, about initially
17 enjoying school and achieving well, but then both their
18 enjoyment and attainment in school deteriorating after
19 they had been abused.

20 There was a corporate focus on attendance -- school
21 attendance, that is -- and behaviour, and less focus on
22 overall wellbeing or recognition of the short-term
23 warning signals or potential for long-term developmental
24 and aspirational effect.

25 Secondly, there was an over-reliance on single,

1 long-standing individuals who had disproportionate
2 control over the home or establishment. Houseparents or
3 other managers were left without proper supervision.
4 Minimal staffing levels afforded greater opportunity for
5 abuse to go undetected and those staffing levels
6 emboldened perpetrators. And learned counsel to the
7 Inquiry referred directly to Mr Harley's own evidence in
8 that regard.

9 Thirdly, my Lady, there was an absence of safeguards
10 such as training procedures and record-keeping, which
11 would have provided better oversight and monitoring of
12 homes.

13 The appearance of these themes across the phase's
14 evidence as a whole is suggestive of broader structural
15 weaknesses within residential childcare during the
16 period.

17 Turning to my final submissions, my Lady, on whether
18 there are other matters to address. The council has
19 since undertaken a combination of criminal justice
20 engagement, survivor support, financial redress and
21 public acknowledgement of responsibility.

22 Disclosures from 1994 onwards resulted in police
23 investigations and multiple criminal convictions against
24 Peter Harley, who was convicted in 1996 and subsequently
25 in later proceedings. The council's role initially at

1 that stage was largely reactive, co-operating with
2 justice agencies, once allegations had reached a level
3 of formal complaint.

4 In the years that followed, the council moved
5 towards formal recognition of the harm suffered by
6 former residents. This included issuing a public
7 apology in the year 2000, acknowledging the abuse had
8 occurred within a home for which it bore responsibility
9 as the successor local authority.

10 In terms of financial redress, the council later
11 developed an ex gratia compensation scheme, offering
12 payments to survivors without requiring them to waive
13 legal rights. The scheme, introduced in the late 2000s,
14 represented an attempt to provide some measure of
15 recognition and reparation outside of litigation. That
16 scheme remains open and to date has paid out over
17 £1 million to ex-Merkland residents over 52 individual
18 payments.

19 Alongside financial redress, there was recognition
20 of the importance of support to survivors, including
21 access to social work services, counselling and
22 signposting to broader redress and support frameworks.

23 The Inquiry heard about steps the council took to
24 provide ex-residents with the means to access
25 counselling and legal advice and the considered manner

1 in which it did so to remove as many barriers as
2 possible to survivors accessing that support.

3 What cannot be forgotten or ignored in that was the
4 central role played by survivors in driving that
5 forward.

6 In closing, my Lady, the council is grateful that it
7 was able to participate in this phase of the Inquiry.
8 We acknowledge the courage of those witnesses who shared
9 their stories and I can assure them that the council has
10 paid close attention to them.

11 I repeat on behalf of the council its sincere
12 apology to all those who suffered abuse at Merkland, and
13 I reaffirm our commitment to ensuring, so far as
14 possible, that what happened there is never repeated.

15 Thank you, my Lady.

16 LADY SMITH: Thank you very much, Mr Thom.

17 Next I turn to CrossReach and I see Ms Macleod is
18 here to address me for CrossReach.

19 Ms Macleod, when you're ready.

20 Submissions from Ms Macleod

21 MS MACLEOD: Thank you, my Lady. I'm Mary Macleod and
22 I'm here representing CrossReach today.

23 The Church of Scotland is one of the largest
24 providers of social care in Scotland. Its involvement
25 in this work is longstanding. In the modern era, its

1 earliest participation in residential care for children
2 came with opening of a home for orphan girls in South
3 Queensferry around 1868.

4 LADY SMITH: Ms Macleod, can I ask you to have your
5 microphone just a little bit closer; that would help me.

6 MS MACLEOD: I've moved it a bit closer now, is that better?

7 LADY SMITH: That's much better, thanks.

8 MS MACLEOD: Good.

9 In 1904, the church's committee on social work was
10 brought into being and that committee is now known as
11 CrossReach.

12 The church has therefore been engaged in the
13 provision of residential care and schooling throughout
14 the period the Inquiry is investigating, and during that
15 period has cared for thousands of children.

16 This phase of the Inquiry's work has considered
17 abuse which took place at a children's home run by the
18 church, The Lord and Lady Polwarth Home in Edinburgh.
19 This home was opened in 1945 originally as a home for
20 under-5s and subsequently providing care for both boys
21 and girls of school age.

22 It closed in 1982 as a result of low admission rates
23 following policy change by local authorities moving away
24 from placing children under 12 in residential care
25 homes.

1 In 2013, the church became aware that an individual,
2 Ian Samson, had been convicted of sexual offences
3 against eight children in the Polwarth home between 1975
4 and 1981. He was in part-time employment by the church
5 at the time of these offences and his appointment was
6 linked to the role of his wife as the matron, who was in
7 charge of the home.

8 Prior to the conviction, the church had not known of
9 the charges. As soon as the church became aware of the
10 conviction, a verbal apology was offered to survivors.
11 That was followed up in writing with a letter to
12 survivors issued through Police Scotland, expressing
13 deep regret for the harm that had been experienced,
14 together with an offer of support.

15 The sentencing remarks made by Lady Scott in the
16 context of Ian Samson's conviction in 2013 prompted the
17 church to commission an independent review by Professor
18 Andrew Kendrick to examine its whole safeguarding
19 system, policies and procedures, specifically including
20 recruitment procedures.

21 All of the recommendations of that report were
22 implemented in 2016 and action plans are in place which
23 seek to ensure continuous improvement.

24 That includes the development and implementation of
25 a robust quality assurance system for safeguarding and

1 child protection practice within CrossReach services.

2 The Church of Scotland's safeguarding service has
3 oversight of CrossReach's internal safeguarding policies
4 and practices and it also undertakes quality assurance
5 activity independently of CrossReach.

6 Governance of the safeguarding service is via the
7 general assembly's safeguarding committee, which also
8 operates independently of CrossReach. This supports
9 robust scrutiny of quality and identification of good
10 practice and any necessary improvements in practice.

11 Engagement in national practice networking fora also
12 provides an additional route of promoting best practice
13 and ensuring that practice in the residential children's
14 home services evolves in line with current research,
15 legislation and national guidance.

16 For example, the church's Head of Safeguarding and
17 CrossReach's Head of Care are members of the Scottish
18 Physical Restraint Action Group, which is hosted by the
19 University of Strathclyde. That work's focused on
20 reducing the use of restraint and promoting the use of
21 reflective practice in the context of restraint and
22 supporting emotional co-regulation of children and young
23 people who have experienced trauma.

24 The group has developed a specialised reflective
25 practice model, known as 'Reflective action and learning

1 forum', and our Head of Safeguarding has served on the
2 oversight board for this model and its methodology has
3 been implemented within the children's residential --
4 within the church's residential children's homes.

5 It was of grave concern to the church to learn that
6 Ian Samson had been convicted of nine charges of
7 indecent exposure prior to his appointment to the post
8 in Polwarth in 1975. The church now has no records
9 relating to his employment or to his appointment. It
10 believes that had this information been available at the
11 time, he would not have been appointed. At the relevant
12 time, while references would have been required, these
13 would focus on faith and character, and conduct of this
14 nature would certainly have been expected to result in
15 a veto on employment.

16 As the Inquiry is aware, there was at the time no
17 national requirement for qualifications for employment
18 in residential childcare. That didn't become
19 a requirement until 2002. A more detailed policy on the
20 recruitment and selection of staff was adopted by the
21 church in 1978 and statutory safeguards to prevent
22 unsuitable people from working with children were
23 established by the Protection of Children (Scotland) Act
24 2003 and developed in subsequent legislation.

25 The church now strives to model best practice in the

1 recruitment and retention of staff across all of its
2 services. I'd like to quote from a Care Inspectorate
3 report from February of this year on a residential
4 service operated by CrossReach. The report notes that:

5 'Strong recruitment processes were in place. These
6 helped identify the suitability of potential staff for
7 support work. Induction processes ensured that staff
8 were regularly assessed to make sure they were
9 appropriately trained to begin providing effective
10 support to people. These systems reduced potential
11 risks for people experiencing support.'

12 One incident of concern relating to Ian Samson
13 during his employment at Polwarth is known from the
14 church's records. Two nude photographs of a child were
15 found by a member of staff and, because of the location
16 in which the photographs were taken, there was
17 a suggestion that Ian Samson may have been implicated.

18 The child was interviewed by staff of the church and
19 of the local authority and said that another child had
20 taken the photographs but would not say who. The
21 incident was reported to the police by the church. The
22 police carried out an investigation, interviewed the
23 child and Ian Samson, but concluded that there was no
24 evidence to proceed with charges.

25 It appears that Ian Samson had previously been

1 issued with an instruction in relation to this
2 particular child. A former member of staff had reported
3 that she had witnessed inappropriate behaviour between
4 him and the child. After the finding of the nude
5 photographs, he was issued with a written warning, based
6 on what was referred to as his 'injudicious association'
7 with the girl.

8 At the same time, the church's Director of Social
9 Work requested the local authority to remove the child
10 and her siblings from the home immediately. This was
11 resisted by the local authority, which stressed the
12 complete lack of evidence against Ian Samson and that
13 the child and her siblings regarded Polwarth as their
14 home and had lived there for 11 years.

15 Ian Samson left the employment of the church
16 voluntarily within a matter of months after this
17 incident.

18 Inquiry counsel asked whether there was a degree of
19 naivety in the way in which this incident was handled by
20 the church. Viv Dickenson, our Chief Executive Officer
21 of CrossReach, was open in conceding that that may have
22 been the case. The fact that a police investigation had
23 found no evidence of wrongdoing may well have
24 contributed to that naivety.

25 The church accepts the evidence which has been

1 submitted to the Inquiry by two witnesses. The victims
2 who suffered the worst of the abuse perpetrated by
3 Ian Samson have chosen not to participate in the
4 Inquiry, but it is important that the facts of what they
5 endured are recorded in these proceedings, as was done
6 through the questioning of Ian Samson by Inquiry
7 counsel.

8 The church has advised the Inquiry that it has
9 settled five claims which have been made by survivors of
10 abuse by Ian Samson at Polwarth. It became apparent to
11 the church in 2020, in the context of one of these
12 claims, that the culture fostered by him in the home had
13 allowed peer abuse to develop and, for this, a further
14 apology is made.

15 It is inescapable that the church has provided
16 a setting in which children have been abused. That is
17 a matter of profound regret by all associated with the
18 church's social care organisation and, indeed, for all
19 connected to the Church of Scotland in any way.

20 If the Inquiry identifies further steps which the
21 church could and should have taken to prevent any abuse
22 which has occurred, the church will take the utmost care
23 to ensure that any necessary changes to practice are
24 made.

25 The church's general assembly in 2024 approved

1 a policy intended to provide support for survivors of
2 historical abuse, which was developed in collaboration
3 with representatives from organisations for survivors of
4 abuse and survivors themselves.

5 This policy aims to ensure that survivors are heard,
6 understood, believed and supported; to provide
7 a sensitive and effective response for survivors who
8 report any type of abuse; to treat all disclosures of
9 historical abuse seriously, respond appropriately and in
10 a timely way; to make sure that survivors and all church
11 workers know what process and procedures will be
12 followed if someone discloses abuse.

13 We strive to understand the possible impact of
14 trauma on the person disclosing abuse and the best way
15 to respond to it in a way that will prevent further
16 trauma to the individual.

17 It also aims to create a healthy safeguarding
18 culture of listening, respect, openness and
19 transparency; to encourage an environment where people
20 feel safe to disclose abuse, and also to ensure that
21 disclosures of alleged criminal activity or a current
22 risk of significant harm is shared appropriately with
23 police or other public authorities.

24 The church recognises that adopting this policy
25 alone doesn't create a culture in which people who have

1 experienced abuse feel confident that they will receive
2 a trauma-informed, person-centred response that avoids
3 re-traumatisation, should they disclose abuse.

4 To support this, the church has revised its
5 safeguarding learning pathway and the training content
6 for each level within it. Those in leadership roles are
7 required to progress through all stages of the pathway,
8 which concludes with a strong focus on the culture of
9 safeguarding.

10 This leadership phase for the pathway has been
11 rolled out over the last 18 months and there's been
12 a notable increase in the awareness of the importance of
13 visible safeguarding across the church.

14 The safeguarding service has assumed responsibility
15 for directly facilitating training in order to ensure
16 consistency and effectiveness, and that's mirrored in
17 the training for senior staff and managers within the
18 church's residential children's homes and school.

19 In addition, the church's ministers' handbook
20 provides practical guidance on how to respond to
21 disclosures and how to access support to ensure that the
22 response is appropriate to the needs of the individual.

23 In essence, the aim of the training is to ensure
24 that the initial response to a disclosure is one of
25 understanding and empathy, which enables the individual

1 to feel heard and accepted. As practical support
2 requirements need to be highly individualised, the
3 safeguarding service take responsibility for this aspect
4 of support, either directly or via the trusted person
5 receiving the disclosure.

6 The safeguarding service also develop and review the
7 content of all other training courses in the learning
8 pathway within the church and the content, of course, is
9 facilitated by CrossReach.

10 The corporate management team at CrossReach have put
11 systems in place to monitor the take-up of safeguarding
12 training and they discuss this at a quarterly
13 performance meeting. CrossReach board members have an
14 annual input from the church's Head of Safeguarding on
15 their own responsibilities when it comes to safeguarding
16 within the organisation.

17 One theme emerging from the Inquiry is the
18 importance of listening to children as an integral part
19 of safeguarding practice. Each year, CrossReach
20 conducts an anonymised survey to gather feedback from
21 the people it supports, helping to benchmark services
22 against national care standards.

23 The survey also allows supported people to choose
24 words that best reflect their experience of support.

25 LADY SMITH: No pre-populated drop-down menus?

1 MS MACLEOD: No. No.

2 LADY SMITH: Good.

3 MS MACLEOD: This year, 521 people completed the survey and
4 the four most commonly selected words were: 'safe',
5 'happy', 'supported', and 'listened to'.

6 In conclusion, all of this speaks to the practices
7 and culture of today, and whilst CrossReach understands
8 that there is no room for complacency, hope that this
9 statement provides some reassurance that everything
10 possible is being done to make sure that the failings of
11 the past are not repeated.

12 To those who endured abuse in Polwarth 40, 50 years
13 ago and whose lives have been immeasurably impacted as
14 a result, the church expresses its sorrow at what
15 happened.

16 Recognising that the events of the past can't be
17 changed, the church nevertheless offers a heartfelt
18 apology to all who have suffered in its care.

19 LADY SMITH: Thank you very much, Ms Macleod.

20 MS MACLEOD: Thank you.

21 LADY SMITH: Now I'd like to turn to the representation for
22 Perth & Kinross Council, so that's to Ms Rodger when
23 you're ready. Thank you.

24 Submissions from Ms Rodger

25 MS RODGER: Thank you, my Lady. Yes, I'm Sarah Rodger,

1 I'm appearing on behalf of Perth & Kinross Council today
2 at the Inquiry.

3 My Lady, you will recall that Perth & Kinross
4 Council is participating today in relation to two
5 children's homes which were operated by the council's
6 predecessor authorities, and those homes are Colonsay
7 House and Nimmo Place.

8 My Lady, written submissions are before the Inquiry
9 and, as set out in those submissions, other
10 documentation has also been submitted during the
11 preparatory phase of the hearings, which have taken
12 place over the last few months. And those submissions
13 further set out the context of the two homes, so I don't
14 intend to go into that any further this afternoon, just
15 for the sake of brevity.

16 The Inquiry heard evidence from Mr Arun Singh in
17 relation to these two homes. Mr Singh is the council's
18 Chief Social Work Officer. He's here with me again
19 today. And we do hope that this evidence was helpful,
20 both in terms of Mr Singh's reflections on the practices
21 at the time in both homes, but also in relation to his
22 professional views about current policy and practice,
23 for example in relation to matters such as The Promise,
24 recruitment and residential care more generally.

25 My Lady will recall that Perth & Kinross Council no

1 longer operates its own residential establishments for
2 children and, perhaps somewhat unusually for local
3 authorities, instead developing an intensive community
4 support model for young people who could be described as
5 being on the edges of care.

6 And I do just want to restate that notwithstanding
7 that situation, the council fully recognises the
8 significance, importance and value in actively
9 participating in this phase of the Inquiry.

10 And my Lady, as I outlined in our opening
11 submission, the council still employs considerable
12 numbers of staff who work directly with children and
13 also the council still places children within
14 residential establishments run by other organisations.
15 So the council's position is that it still has a great
16 deal which it can learn from the evidence which has been
17 heard.

18 LADY SMITH: And also in foster care.

19 MS RODGER: Apologies, my --

20 LADY SMITH: The council also places children into foster
21 care.

22 MS RODGER: Yes, exactly, my Lady. Foster care and kinship
23 care.

24 LADY SMITH: Yes.

25 MS RODGER: I want to assure the Inquiry on behalf of the

1 council that the council is also using this opportunity
2 to shine a light, not just on historic practice of its
3 predecessor councils, but on its current practice across
4 a range of areas, which I will come onto in a moment.

5 And I hope the Inquiry will see from our submissions
6 that we do continue to reflect on our current practice,
7 and the work of the Inquiry has been invaluable in that
8 and we believe the learning we've taken from this
9 process will have a lasting impact for current and
10 future children who need support and intervention from
11 social work to keep them safe.

12 Before I turn to specific submissions on the
13 evidence that's been heard, my Lady, I do wish to extend
14 again, in this public forum, an apology on behalf of
15 Perth & Kinross Council. The council wishes to take the
16 opportunity to acknowledge the bravery of all of those
17 applicants who have come forward to the Inquiry to share
18 their experiences in Colonsay House and in Nimmo Place.

19 Mr Singh and I listened to the evidence given by the
20 two witnesses who attended the Inquiry and have read all
21 of the applicants' statements and we acknowledge the
22 heavy toll that this will have taken on all of those
23 individuals to share their stories, particularly given
24 the lifelong impact that their abuse has had on them.

25 And the council fully acknowledges the lasting

1 impact and trauma that such experiences have had,
2 without exception, on all of those who provided
3 a statement to the Inquiry.

4 And I think I would like to make particular mention
5 of the two individuals who gave evidence to the Inquiry.
6 I think it was devastatingly clear, when listening to
7 those individuals, that their experiences in care at
8 Colonsay House and Nimmo Place have had a lasting,
9 deeply traumatising impact on them. And on behalf of
10 the council, I do wish to assure them and all of the
11 other applicants that they have been listened to and we
12 are determined to learn lessons from their experiences.

13 So, on that note, the council again wishes to
14 express its sincere and unreserved apology to all of
15 those who suffered abuse, ill-treatment or neglect while
16 in care within either of those homes. We deeply regret
17 the pain and trauma caused by failings, both at
18 an individual and systemic level, which have come to
19 light as part of this Inquiry. We do recognise though
20 that no apology can undo the harm that those people have
21 experienced.

22 Turning now to findings in fact, my Lady. Our
23 written submissions in sections 3 to 12 address this in
24 much more depth and I don't intend to address that in
25 depth this afternoon.

1 However, in broad terms, it's my submission that the
2 Inquiry would be entitled on the evidence to make
3 findings that in both homes, children suffered
4 physical -- serious physical, emotional and sexual abuse
5 and that this was prolonged, sustained and widespread.

6 My Lady, it was described by one of the applicants
7 who gave evidence as 'relentless', and the council
8 accepts that, based on the evidence, this is
9 an appropriate term to describe the experiences of
10 children who should have been safe and cared for.

11 In relation to physical abuse, again there's
12 evidence of a culture which included, at Colonsay,
13 hitting and punching by staff and children, threats,
14 intimidation, as well as cruel punishments such as cold
15 baths. And it's difficult to hear that these are
16 consistent themes that have been spoken about this
17 afternoon.

18 Children lived in an environment where they were
19 emotionally abused, demeaned, intimidated, treated with
20 hostility and exposed to others being abused and,
21 I would add, in line with other comments that my
22 colleagues have made this afternoon, significant
23 evidence of children being forced to abuse each other,
24 which is deeply distressing to hear.

25 There was an absence of nurturing, care and

1 emotional support.

2 In relation to Nimmo Place Children's Home, in its
3 early period, there was what can be described as
4 an ingrained culture of over-chastisement of children,
5 humiliation, physical punishments, such as
6 force-feeding, cold baths, being forced to stand in
7 corners for lengthy periods of time, and again, an
8 absence of nurturing care.

9 And in later years, young people experienced
10 excessive use of restraint, with all of the risk and
11 trauma that that brings with it.

12 And lastly, in relation to sexual abuse, we now know
13 that Peter Murray has been convicted in relation to
14 sexual abuse of two former residents at Colonsay House,
15 although we do know from the evidence, he was charged
16 back in 1993 in relation to a number of other counts,
17 but the Crown didn't proceed with those particular
18 charges.

19 The evidence heard in relation to his role at both
20 homes was deeply distressing and would suggest he was
21 able to sexually abuse a number of young people across
22 both homes. But the Inquiry also heard other evidence
23 about sexual abuse by other staff, which included
24 inappropriate sexual touching, voyeurism and, as
25 I've just mentioned, forcing children to abuse each

1 other.

2 Turning now to the failures that have been
3 identified as a result of the evidence. Again, these
4 are more fully set out in my written submission, but the
5 council accepts that the evidence indicates that what
6 children experienced was, as Mr Singh described it,
7 a whole-system failure.

8 And, in fact, Mr Singh went further in his evidence,
9 I think, than the council had done in its updated
10 Section 21 response, which it submitted last October.
11 He accepted that, having heard all of the applicant
12 evidence, it couldn't be described as anything other
13 than a whole-system failure.

14 And I think that that encompassed a number of areas.
15 There were failures in recruitment processes, which
16 lacked rigour in the first place, and then also lacked
17 rigour as Peter Murray moved through the organisation,
18 for example, failing to pass on information about the
19 verbal warning that he had received. Failures in
20 supervision and training. This was a member of staff
21 employed with no experience of caring for children and
22 there was no system in place for staff to be supervised.

23 I'm sure Mr Murray was not alone in that, in terms
24 of being employed on that basis.

25 And in my submission, this meant that even where

1 there were rules in place, they weren't enforced. And
2 the Inquiry did hear that there was a standing rule, for
3 example, about making sure that staff did not enter
4 bedrooms, which seemed to be flouted more than it was
5 complied with. Although I do have to say, I wonder if
6 that rule was more about protecting staff than
7 protecting children.

8 LADY SMITH: Mm-hmm, yes.

9 MS RODGER: I think there were failures in culture where
10 children were viewed as problematic and there was
11 an ethos of control and not care. And a failure to
12 provide children with access to safe spaces and people
13 that they could feel able to share concerns and abuse
14 with. And I think that that probably compounded the
15 feeling among all of the children, and a number
16 mentioned this in their statements, that reporting was
17 seen as futile because they didn't think they would be
18 believed or that nobody was interested.

19 There were failures in management and leadership to
20 establish effective safeguarding systems, supervise
21 staff conduct and respond to known concerns. There was
22 really no effective accountability.

23 Turning now to complaints and investigation
24 processes, again, I think the evidence would suggest
25 that there was a failure in every aspect of this, which

1 meant that abuse was able to continue unchecked. There
2 was no effective independent investigation when
3 allegations were made and allegations were minimised,
4 and where there was an apparent bias towards staff
5 accounts over those of children which, I think, my Lady,
6 has already been mentioned this afternoon in another
7 context.

8 There were no effective internal safeguarding
9 processes while investigation was ongoing, such as
10 precautionary suspension, and no wider investigation to
11 determine if there were other issues or if other young
12 people had similar experiences to those who had been
13 brave enough to make an allegation.

14 In the case of Peter Murray, my Lady, even where
15 a second allegation was made, a number of years later --
16 I think it was perhaps two years later -- it appears
17 there was no effective independent investigation in
18 relation to that either, and no attempt to reflect on
19 the fact that that had now been the second allegation
20 made.

21 Turning now to how those failures have been
22 addressed, again, I have more specifically dealt with
23 this in written submissions, particularly in relation to
24 national changes which have taken place, but I did want
25 to briefly highlight a number of matters today.

1 In relation to the voice of the child, Mr Singh
2 acknowledged in his evidence that even with all of the
3 efforts being made today to ensure that the voice of the
4 child is heard, and that young people are safe to speak
5 up, children who are in care have an inherent
6 vulnerability because of their circumstances.

7 And in my submission, that means there is a need for
8 continual vigilance because of this. And that requires
9 deliberate, consistent and creative efforts to ensure
10 that the voice of children is heard, and, very
11 importantly, that they are able to develop and maintain
12 those trusting relationships that are so important to
13 helping them feel safe.

14 The council is not complacent about this, my Lady,
15 especially as children from Perth & Kinross may be
16 placed at considerable distance from their families and
17 other trusted adults.

18 And as a result of the evidence heard during this
19 phase of the Inquiry, the council has recognised the
20 need to reflect further on the standards and principles
21 which should be used to guide planning for contact
22 between children and social work staff, and will use the
23 evidence from the Inquiry to aid in that task.

24 Moving on to a connected issue, my Lady, that of
25 professional curiosity, and again a number of people

1 have mentioned that during the course of today. This is
2 a vitally important aspect of social work practice and
3 the evidence the Inquiry and the outcome of repeated
4 national reviews has demonstrated is how critical this
5 is for all children who are at risk, particularly those
6 who have that inherent vulnerability of being in care
7 and away from their families.

8 And again, my Lady, our written submission sets out
9 the council's approach to this in more depth currently.

10 And the council is currently reviewing its approach
11 to professional curiosity because it's recognised
12 potential new challenges being faced within our
13 organisation because of our relatively young and fairly
14 inexperienced workforce.

15 My Lady, there's a recent case review been published
16 by Glasgow City Council just last month and that has
17 a section in it in relation to professional curiosity,
18 which indicates this is a recurring theme that comes up
19 in many reviews. And the learning from that Glasgow
20 case review is already being done within the council.

21 LADY SMITH: Thank you.

22 MS RODGER: And that's vital to ensure that our workforce
23 and systems are equipped to meet the needs of children
24 and keep them safe.

25 In relation to recruitment and selection, my Lady,

1 a lot has been said about that during the course of the
2 day and I think it's accepted that practice has involved
3 (sic) considerably in relation to perhaps qualifications
4 and the professionalisation of the social services
5 workforce. But I do think, my Lady, that the evidence
6 heard in relation to Peter Murray in particular is
7 a salutary reminder of the importance of applying rigour
8 to every stage of the recruitment process, which goes
9 far beyond someone's qualifications.

10 Our written submissions address more fully the
11 current recruitment approach that the council uses,
12 where there's a robust process to explore key areas,
13 such as motivation, employment history and a focus on
14 values and behaviours, not just qualifications.

15 But we equally recognise there's a need to
16 continually re-evaluate our safe recruitment guidance
17 and processes so they are fit for purpose and so staff
18 have the necessary skills and values to undertake this
19 most difficult of tasks.

20 And Mr Singh, in his evidence, was happy to
21 undertake to raise some of the reflections and learning
22 that he took from his evidence at the Inquiry with
23 national forums that he is part of, and has also
24 committed to looking at the council's recruitment and
25 guidance processes with the benefit of the Inquiry's

1 evidence alongside our HR colleagues in the council.

2 In relation to the management of allegations, the
3 Inquiry will be aware of the evolution of national
4 approaches to child protection and in Perth & Kinross,
5 those are reviewed and practice audited via our Child
6 Protection Committee.

7 In the particular context of residential care,
8 my Lady, our written submission provides clarity in
9 relation to the questions raised during Mr Singh's
10 evidence about the interplay between contractual
11 frameworks and child protection processes, given that we
12 effectively outsource our residential care provision.

13 Those clarifications are contained in section 27 of
14 our written submission and we hope that that will be
15 helpful to the Inquiry.

16 In relation to culture and leadership, my Lady,
17 again this has been addressed perhaps elsewhere this
18 afternoon, but we can see from the evidence heard by the
19 Inquiry that without strong effective leadership and
20 culture, the risks to children in residential care, and
21 indeed any form of care, are significant.

22 The effectiveness of policy and procedure which does
23 now exist depends on the culture and effectiveness of
24 leadership in the organisation. And I would only add
25 here that in practice, that involves continuous

1 reflection and improvement, so staff have the skills and
2 competencies they need to be able to safeguard children
3 and young people, but also staff need to feel supported
4 and enabled to raise concerns and issues, to be
5 assertive, confident and transparent.

6 My Lady, the last point I wish to make in my closing
7 submissions relates to case records and I am aware this
8 has been raised already, but I do want to particularly
9 make mention of it here.

10 The adequacy of case records is a recurring theme
11 and is of grave concern to the council and, as we've
12 heard today, this is a recurring issue in front of the
13 Inquiry as well.

14 The council accepts that poor recording and
15 retention practice is intolerable for those who wish to
16 understand the experiences of children in care, whether
17 that's the Inquiry or whether it's adults looking to
18 understand their own care experience. And that's
19 a failure which clearly still has an impact today and
20 indeed the council has seen it in its own attempts to
21 understand what happened in the past.

22 And in that context, we acknowledge that our own
23 awareness of practice in both of these homes would not
24 be known about, but for the Inquiry, and but for the
25 evidence given by applicants, because the record-keeping

1 doesn't provide that richness of detail that we would
2 have required.

3 I wanted to make one other point about our role as
4 custodian of historic records. We acknowledge that
5 an exercise carried out some years ago to preserve our
6 records digitally, in relation to historic children's
7 social work records, was not undertaken with a view to
8 making those records accessible in a suitable way,
9 especially for adults who wish to have access to their
10 records today.

11 The manner in which those records have been
12 digitally stored means it can be very difficult for
13 adults to gain the coherent story that they need. And
14 my Lady, the learning has been absorbed in relation to
15 that and we'll continue to review that.

16 In response to that, our own data protection team
17 have looked to continually improve their approach and
18 ensure that, as far as they're able to, they can respond
19 to this challenge and approach the task of identifying
20 and sharing records in a sensitive, trauma-informed way.

21 And it really is deeply regrettable, my Lady, that
22 for some adults, there is little or nothing recorded
23 about their historic experiences in care, and one can
24 only imagine the further trauma that that causes some of
25 those individuals.

1 Mr Singh is committed to reflecting further on how
2 the council can improve its approach so that adults can
3 access their files in a sensitive way and in a way where
4 support's available when it's needed. And work is
5 underway already to provide an opportunity for adults
6 who've accessed their records to give feedback about
7 their experience.

8 Case recording more widely is also under review in
9 the council, moving towards a model of child-centred
10 case recording. This is explained more fully in our
11 written submission, my Lady, so I won't go into further
12 detail about that at the moment.

13 But the reflections of some of the applicants in
14 this and previous phases of the Inquiry in relation to
15 recording practice will be valuable in informing that
16 work, and I think it does remind us of the importance of
17 the task of recording.

18 And the last change in practice that we're currently
19 thinking about and reviewing relates to the approach of
20 the organisation to storing and sharing cherished
21 documents.

22 So the council does retain items such as photos and
23 other memories in their original form, rather than
24 digitally, and we're now beginning to review that to
25 ensure that we're approaching that in a way that is --

1 best meets the needs of both children and adults who may
2 wish access to those documents.

3 So my Lady, we hope that all of this means that the
4 Inquiry can see that the council isn't complacent about
5 the scale or complexity of the task of keeping children
6 in its care safe. It's an ongoing task, which requires
7 constant review and reflection, and the council is
8 committed to learning from the Inquiry so that it can
9 continue to make that difference to how children and
10 young people are cared for and kept safe.

11 Thank you, my Lady.

12 LADY SMITH: Ms Rodger, thank you very much. That's very
13 helpful to have heard from you.

14 It's now nearly 3.10 pm. I'll take the short
15 afternoon break just now and then we'll return, and the
16 next submissions I'd like to hear are for Edinburgh City
17 Council, so that will be Mr Batchelor again after the
18 break.

19 Thank you.

20 (3.09 pm)

21 (A short break)

22 (3.20 pm)

23 LADY SMITH: Now, Mr Batchelor, the
24 City of Edinburgh Council.

25

1 time. And it opened in 1970 and closed in 1985.

2 And although in some respects it was more suited to
3 children's needs, there were still significant
4 shortcomings in how it operated, which allowed children
5 to be abused there -- and I'll come back to this,
6 my Lady, but particularly the way in which Gordon Knott,
7 who was the officer-in-charge, basically ruled the
8 roost, if it can be put that way.

9 Both of the homes closed in the 1980s due to the
10 general transition away from residential care towards
11 more community-based care.

12 Edinburgh City Council acknowledges, my Lady, that
13 children cared for at Glenallan and Clerwood were
14 abused. Children there were sexually, physically and
15 emotionally abused, and that abuse was widespread.

16 The council apologises to all those who suffered
17 abuse as children at Clerwood and Glenallan. The
18 council is deeply sorry. They apologise not only for
19 the abuse which those children suffered, but also for
20 the shortcomings in their systems and for their failures
21 to respond appropriately to disclosures of abuse.

22 During the case study, my Lady, importantly the
23 Inquiry has had the benefit of the Edinburgh Inquiry
24 report. That's a very detailed report which was
25 published in January 1999. It was commissioned, as

1 your Ladyship will be aware, following the conviction of
2 two members of staff, Gordon Knott and Brian MacLennan,
3 for sexual abuse of children at Glenallan, Clerwood and
4 another establishment.

5 It was an extremely thorough report, in my
6 submission, which considered the nature and extent of
7 abuse which occurred at both Clerwood and Glenallan, and
8 also it considered failures in the response to reports
9 or indications of abuse and the systems which were in
10 place at the time.

11 And the Inquiry was also fortunate to have the
12 benefit of hearing from one of the authors of the
13 report, Kathleen Marshall, who provided extremely
14 helpful evidence on Day 599 and, in my submission, the
15 Inquiry can -- it finds itself on very solid ground
16 making findings in fact based upon the findings of the
17 Edinburgh Inquiry report and on Mrs Marshall's evidence.

18 The Inquiry has also heard evidence from both
19 applicants and some former members of staff and has had
20 witness statements from others.

21 As has been alluded to by senior counsel to the
22 Inquiry, evidence was heard from one of the convicted
23 abusers, Gordon Knott, on Day 600. Whilst he accepted
24 that he abused children, he continues to dispute the
25 nature and extent of that abuse, including in respect of

1 matters where he's been convicted.

2 And whilst the Inquiry may wish to have some regard
3 to Mr Knott's evidence as to how the -- how Glenallan
4 and Clerwood operated, the council would submit the
5 Inquiry should really discount Mr Knott's evidence so
6 far as it relates to the nature and extent of his
7 offending. It's not considered that that was of any
8 particular assistance to the Inquiry.

9 Turning to the nature and extent of abuse, my Lady,
10 I would adopt what's said in the written submission.
11 The focus has principally been on the sexual abuse which
12 occurred at these establishments.

13 And just to reiterate points which Mr MacAulay made
14 in his opening, there are three criminal convictions in
15 relation to two -- or two separate sets of proceedings
16 against Mr Knott and a set of proceedings against
17 Mr MacLennan.

18 In 1997, Mr Knott was convicted of the sexual abuse
19 of children at Clerwood from 1973 to 1997 and at
20 Glenallan from 1978 to 1983. And the indictment
21 included 22 charges and he was convicted of 10 offences
22 against nine children and sentenced to 16 years in
23 prison.

24 Mr MacLennan was sentenced to 11 years' imprisonment
25 for crimes committed in Clerwood from 1977 to 1978 and

1 at another establishment, which wasn't under the control
2 of the council's predecessors, and there were 14 charges
3 against him.

4 And Mr Knott was prosecuted again in 2018 for
5 further offences against children at Clerwood between
6 1973 and 1981, and he was sentenced to four years in
7 prison in respect of those charges.

8 And it's notable, my Lady, that despite the
9 widespread police inquiries and the thoroughness of the
10 Edinburgh Inquiry in the 1990s, that other victims did
11 not feel able to come forward until much more recently,
12 and that prosecution obviously took place in 2018,
13 nearly 20 years after the Edinburgh Inquiry report.

14 Whilst the principal focus of the criminal
15 proceedings has been on sexual abuse, that wasn't the
16 only issue at Clerwood, and we heard from a former
17 resident who spoke to the Edinburgh Inquiry and to this
18 Inquiry about being forced to eat out of what was termed
19 'the trough'. If children misbehaved, they were told to
20 eat out of a trough, which contained a mixture of all
21 kinds of food and ingredients and was put on the floor,
22 and if they didn't eat it, their heads and faces were
23 pushed into the food on the trays.

24 The Inquiry heard evidence specifically from
25 'Michael' on Day 598 in relation to his recollection of

1 the trough. And a former member of staff, BFW, has
2 provided some written evidence to the Inquiry, although
3 he didn't give oral evidence. BFW was dismissed due to
4 mistreatment of children in 1976 as a result of this
5 practice, my Lady.

6 There's a dispute between BFW and others about the
7 precise facts of what occurred, although the
8 contemporaneous records that are available would tend to
9 contradict BFW's recollection of events about how many
10 children were involved.

11 What I would say, my Lady, is that the Inquiry's on
12 safe ground, even accepting BFW's account, that what he
13 did was abusive.

14 LADY SMITH: It happened, yes.

15 MR BATCHELOR: And it perhaps bears mentioning, my Lady,
16 that BFW himself was a relatively junior and untrained
17 member of staff at the time and he'd come from
18 an institutional care background himself, which may
19 perhaps give us some insight into why he may have
20 considered that sort of behaviour acceptable.

21 Turning to failures in systems, my Lady, I adopt
22 what is said at paragraphs 21 onwards. The issue of
23 recruitment and references is something which has been
24 a recurring theme during this phase and there are two
25 particular points, I think, in relation to Clerwood and

1 Glenallan where that issue rears its head.

2 In particular, Brian MacLennan was able to move from
3 one job to another on the basis of references which were
4 less than open and honest, and reference is made in the
5 Edinburgh Inquiry report to references themselves being
6 used as a way of moving problematic employees on.

7 It's also noteworthy, my Lady, that when BFW was
8 dismissed from his employment in 1976, he didn't
9 disclose the reasons for his dismissal to his future
10 employers, who presumably were entirely unaware of that.
11 And he's gone on to have a lengthy and successful career
12 in social care.

13 However, at the time, due to a lack of, perhaps,
14 regulation, the reasons for his dismissal weren't
15 captured and it was only in 1997, as a result of the
16 Edinburgh Inquiry, that he was actually spoken to by the
17 police.

18 Again, perhaps that underpins the importance of
19 having independent regulatory systems, both for
20 organisations, establishments and for individuals.

21 The next issues, around rotas and sleeping
22 arrangements and lone working and external oversight,
23 are in some ways related, and in particular in relation
24 to Glenallan, where Gordon Knott was the
25 officer-in-charge. He was able to manipulate schedules

1 in order to facilitate his abuse of children, and the
2 Edinburgh Inquiry found that the officer-in-charge of
3 a home was really considered to be the boss, and wasn't
4 perceived by residents to be accountable to anyone else.
5 And that definitely played into the ability of Mr Knott
6 to be able to continue to abuse those in his care.

7 I would adopt what's said in relation to lack of
8 training and awareness of sexual abuse amongst workers
9 as a generality at the time, and social worker
10 caseloads.

11 I've also mentioned there the theme of running away
12 and absconding, my Lady. I think that's something we've
13 seen in virtually every case study and the Edinburgh
14 Inquiry focused on that and found that it wasn't
15 commonplace when a child did run away that the real
16 reasons for them doing so were analysed in detail and
17 discussed with them. And the Edinburgh Inquiry
18 recommended that serious attention should be given to
19 the reasons why a child ran away.

20 Turning to failures in response to allegations,
21 my Lady, that really was one of the main reasons for the
22 establishment of the Edinburgh Inquiry in the first
23 place.

24 At the criminal trial of Knott and MacLennan, there
25 was evidence that previous reports of abuse by them

1 hadn't been acted upon and, following investigation, the
2 inquiry team found there were 18 possible reports of
3 prior abuse which had been made, and chapter 4 of the
4 inquiry report relates to the responses to the reports
5 by victims.

6 The inquiry investigated five possible reports of
7 abuse at Clerwood and three examples of behaviour which
8 appeared to have been attempts to communicate with those
9 in authority to get them to take notice.

10 And, at Glenallan, there were three possible reports
11 and one behaviour.

12 And the inquiry concluded that there were examples
13 where greater efforts should have been made by the
14 police and social work department to follow up on those
15 initial disclosures and to have more structured lines of
16 inquiry.

17 And one specific example, which is quite a chilling
18 example, my Lady, relates to what might be termed the
19 'letter under the door' episode at Glenallan, when
20 a child, G, in respect of whom Mr Knott accepts he was
21 sexually abusing this child, he wrote a note addressed
22 to Mr Knott's wife which accused Mr Knott of sexually
23 abusing him, and that's given a great degree of
24 consideration in the Edinburgh Inquiry report.

25 That incident was not appropriately investigated.

1 The child should have been interviewed by people who
2 weren't junior members of staff and he certainly
3 shouldn't have been interviewed by Mr Knott's wife, and
4 there was also clear evidence that the child was
5 pressured by Mr Knott to withdraw the allegation.

6 Mr Knott was asked about this incident during his
7 evidence to the Inquiry and he denied trying to
8 manipulate the child to withdraw the allegation, but in
9 my submission there's ample reason to reject Mr Knott's
10 account in that regard and to prefer the conclusions
11 reached by the Inquiry.

12 The Edinburgh Inquiry report, my Lady, had
13 a particularly significant influence over developing
14 policy and practice at the City of Edinburgh Council.
15 The report was published in 1999 and it contained
16 134 recommendations, led to a detailed action plan as
17 we've heard evidence about in previous case studies.

18 And following on the report, there was an intensive
19 period of change and recommendation implementation.

20 We've seen from previous case studies that there are
21 issues with ensuring that changes in practice are
22 appropriately embedded and that recommendations or the
23 implementation of recommendations from inquiry reports
24 doesn't just become a box-ticking exercise.

25 On the City of Edinburgh Council's current

1 provision, my Lady, in keeping with national trends, the
2 residential provision for children in Edinburgh is now
3 considerably smaller than it was during the years that
4 Clerwood and Glenallan operated.

5 So City of Edinburgh now operate nine houses,
6 including one house for children with complex physical
7 or medical needs. And the number of children within
8 each house are much smaller, typically around four
9 children in each house.

10 And in keeping again with developments in the
11 sector, practice has evolved with the move away from
12 widespread residential provision to more community-based
13 care, including fostering placements and kinship care.

14 There's obviously been widespread change since the
15 time of the Edinburgh Inquiry report, my Lady, but as
16 I say, City of Edinburgh Council's biggest challenge in
17 recent years has been ensuring that meaningful change is
18 embedded in the organisation and in changing the culture
19 of the organisation.

20 In conclusion, my Lady, the extent of abuse which
21 occurred at Clerwood and Glenallan is both shocking and
22 appalling, as is the fact that it went unchecked for so
23 long, despite reports and despite other signs being
24 there.

25 City of Edinburgh Council wishes to reiterate its

1 apology to all those children who were abused at
2 Clerwood and Glenallan. It's key that lessons continue
3 to be learned from the appalling events that happened
4 there.

5 LADY SMITH: Thank you very much.

6 Turning now to the Ponton House Trust, I'd invite
7 Ms Connelly to address me.

8 Ms Connelly.

9 Submissions from Ms Connelly

10 MS CONNELLY: Thank you, my Lady. Clare Connelly,

11 representing the Ponton Trust.

12 The Ponton Trust participates in the Scottish Child
13 Abuse Inquiry in respect of the Inquiry's investigation
14 of abuse that occurred in the Ponton House Boys'
15 Residence. That establishment later became known as the
16 Edinburgh Home for Working Lads and occupied various
17 premises until 1962, when, due to a decline in demand
18 for places at the home, it moved to smaller premises at
19 6 Magdala Crescent, Edinburgh.

20 Whilst that accommodation was intended to
21 accommodate working lads, the Inquiry has heard that, in
22 the latter years, there were younger children who were
23 still attending school that had been placed within the
24 house.

25 The Ponton Trust is the successor to the earlier

1 bodies that were the recipients of the assets of
2 Ponton House Boys' Residence, when it was dissolved in
3 1982.

4 The present trust has no records relating to
5 Ponton House Boys' Residence, but on the basis of
6 evidence presented, the trustees of the present trust
7 accept that some of those who were resident in
8 Ponton House Boys' Residence were subjected to abuse.

9 LADY SMITH: And I take it it's also accepted that at
10 Magdala Crescent, it was operating more as a hostel.
11 There were older people there, young adults who were
12 working?

13 MS CONNELLY: Yes, my Lady. So there was a combination of
14 older boys up to the age of 21 who were working and, as
15 I've said, these younger children who were placed within
16 the home. That wasn't what the home was initially at
17 least intended for.

18 LADY SMITH: No. And it wasn't operating in any way like
19 something that would be recognised as a children's home,
20 from the evidence that we have, isn't that right?

21 MS CONNELLY: Indeed. That's the case, my Lady. And the
22 Inquiry has heard evidence about issues with the
23 supervision that was made available or the lack thereof,
24 my Lady.

25 LADY SMITH: Indeed.

1 MS CONNELLY: And Mr MacAulay referred this morning,
2 my Lady, to the impact of the instances where the
3 children that were residing in Magdala Crescent were
4 targeted by adults in the community, and that lack of
5 supervision allowed that targeting to take place and be
6 followed through.

7 LADY SMITH: It did. Thank you.

8 MS CONNELLY: My Lady, the trustees of the present charity
9 reiterate their apology to all those whose lives were
10 impacted by the poor practices, inadequate training and
11 lack of adequate staff supervision that enabled
12 detriment to the wellbeing of the former residents of
13 Ponton Trust at Magdala Crescent.

14 The trustees of the Ponton Trust unequivocally
15 condemn and abhor any abuse and offer an apology to any
16 young person who was subjected to abuse whilst residing
17 at the Ponton House in Magdala Crescent and prior to
18 that.

19 My Lady, if I can be of any further assistance?

20 LADY SMITH: I have no other questions. Thank you very
21 much, Ms Connelly.

22 MS CONNELLY: Thank you.

23 LADY SMITH: I'll turn now to Glasgow City Council and that,
24 I think, is Mr Pugh for Glasgow. When you're ready,
25 Mr Pugh.

1 Submissions from Mr Pugh

2 MR PUGH: Yes, thank you, my Lady, it's Richard Pugh KC,
3 appearing on behalf of Glasgow City Council. My Lady,
4 as others have done, Glasgow have their written
5 submission and I adopt that submission. I'm not going
6 to read all of it. Rather, as I've done previously,
7 I'm simply going to highlight the points that are,
8 I think, of greatest importance. And I will, my Lady,
9 try to keep your Ladyship up to date with paragraph
10 numbers as I go through, just to aid following the
11 written submission.

12 LADY SMITH: Yes.

13 MR PUGH: I've set out at paragraphs 1 and 2 the basis upon
14 which -- or the institutions for which the council is
15 here to discuss, but where I want to start is
16 paragraph 3.

17 And at the commencement of this phase, the council
18 acknowledged, my Lady, that abuse took place within each
19 of the institutions run by Glasgow City Council and its
20 predecessors, and it offered an apology to the children
21 and young people who experienced abuse.

22 And it's only proper that, following the closure of
23 this phase of evidence and during a time when the
24 council is reflecting on that evidence, that that
25 apology is once again reiterated to the children and

1 young people who were abused within establishments run
2 by Glasgow City Council and its predecessors. The
3 council is deeply sorry.

4 My Lady, in paragraphs 4 through 6, I've set out
5 again the council's participation in this Inquiry, in
6 this phase of the Inquiry and I'll skip over that, but
7 for this point which arises at paragraph 5: to reiterate
8 again that the purpose of the council's participation in
9 this phase and any other phase of the Inquiry that it's
10 been in, has not been to challenge the accounts of
11 survivors of abuse and the applicants that have given
12 evidence.

13 And with that in mind, if I can turn then to the
14 applicant evidence. This is from paragraphs 7 onwards
15 and, my Lady, just to be clear, this is not
16 a comprehensive summary of the evidence, but rather
17 again it's designed to try to draw out themes from that
18 evidence.

19 This phase of the Inquiry has yet again been
20 challenging for the council. The evidence heard has
21 testified to serious abuse. There is no doubt that such
22 abuse was as a result of systemic failures in the
23 protection of children, as was accepted by Susanne
24 Millar when she gave evidence.

25 In the next couple of paragraphs, I've pointed to

1 some of the restrictions on the council's knowledge and
2 I'm just going to rely on what's said in writing there,
3 but for the point made at the end of paragraph 8, that
4 the council accepts that there are echoes of the
5 situations at institutions which have been looked at
6 previously in this Inquiry and, as I'll come on to set
7 out, many of the same themes arise as arose in
8 particular to some extent in the Foster Care case study,
9 but certainly in the Residential Care case study in
10 Phase 8 and I'll come back to that point, if I can,
11 my Lady.

12 If I can then go from paragraph 10 and dealing first
13 with the children's homes and, by that, I mean the four
14 homes, but not Forrethy. I'll address Forrethy
15 separately in a moment.

16 LADY SMITH: Thank you.

17 MR PUGH: Dealing first with the children's homes. The
18 applicant evidence discloses, amongst other things,
19 firstly in relation to Park Lodge, serious and
20 significant sexual abuse by Alistair Findlay. This was
21 spoken to by applicants 'Cameron' and 'Rita', both on
22 Day 605. Findlay has, of course, been convicted for his
23 abuse of children including in relation to 'Cameron'.

24 Moreover, my Lady, the evidence from Park Lodge,
25 from a variety of applicants, disclosed a culture of

1 peer-on-peer bullying, evidence of staff bullying and
2 inappropriate restraint or excessive discipline or
3 punishment.

4 The Inquiry has, in relation to Park Lodge,
5 an inspection report from 1996, which was discussed with
6 Susanne Millar in evidence. It showed the difficulty in
7 managing the institution, which might have been due to
8 shortages of staff and specialist intervention, and of
9 those we have heard much in the past, my Lady, but it
10 was also likely, in Ms Millar's view, to be contributed
11 to by the physical environment of old Victorian
12 buildings where supervision was difficult and where
13 already thin staff numbers would have found it even
14 harder to supervise what was going on within these
15 premises.

16 In relation to Eversley and Downcraig, I take these
17 together, the evidence has shown serious and significant
18 sexual abuse by John Marshall. That abuse is again
19 subject of criminal conviction. There were also
20 evidence of other staff members associated with Eversley
21 that either had convictions for sexual offences or who
22 had been charged and tried in relation to such offences
23 or investigated by the police in relation to such
24 conduct, and your Ladyship will recall Mr Sheldon's
25 taking Susanne Millar through the spider diagram that

1 had been produced by Glasgow City Council detailing
2 those connections.

3 Those other convictions included Steven MacDonald,
4 who had been a houseparent at Eversley and although his
5 conviction was later appealed due, I think, to
6 corroboration, there was plainly a lot to be considered
7 within that conviction.

8 And it seems that some of the information, as I say,
9 relating to these convictions had been produced by
10 Glasgow City Council at the time of obvious police
11 investigations into these things and I've given the
12 reference number there.

13 Now, my Lady, and this is a key point, what the
14 evidence in this Inquiry has disclosed is that
15 Mr Marshall's abuse, in particular, was allowed to
16 persist, at least in part, by some of the practices at
17 Eversley. Marshall's relationship with his wife allowed
18 him, it seems, to cover up at least one complaint from
19 a staff member following her witnessing his
20 inappropriate behaviour.

21 He also appears to have been allowed to take
22 children away alone or with his wife, who was SNR
23 of the home, a practice Susanne Millar accepted, even
24 for the early 1980s, was not in accordance with proper
25 safeguarding.

1 Now, my Lady, there is some overlap between Eversley
2 and Downcraig with some conflicting indications as to
3 precisely when Eversley closed and Downcraig opened.
4 I don't think I can answer that question for the
5 Inquiry.

6 The logbook produced shows evidence frankly of that
7 overlap in the sense that the logbook is headed
8 'Eversley' or has got the cover of 'Eversley' but
9 plainly refers to matters at Downcraig. But the
10 evidence disclosed that some of the abuse perpetrated by
11 John Marshall happened at that latter institution as
12 well as the former and your Ladyship will recall Mr
13 Sheldon going, I think, it was to charges 4 and 12
14 within the indictment relating to John Marshall that
15 were plainly in relation to Downcraig.

16 The council, of course, takes no issue with the
17 correctness of that conviction and it follows, my Lady,
18 that there's an acceptance that sexual abuse occurred,
19 both in relation to Eversley, which is in the Section 21
20 and in relation to Downcraig, which is -- which, at the
21 time it was drafted, was not known. In addition to the
22 sexual abuse, there's also evidence of excessive,
23 inappropriate and unjustified punishment, for example,
24 that spoken to by 'Sandra' on Day 606.

25 And then in relation to Dunclutha, the evidence of

1 abuse all related to the period prior to 1979. There
2 was evidence of serious physical abuse of young
3 children, including by residents being struck by a dog
4 chain and being forced to fight one another, obviously
5 incredibly difficult evidence to read, my Lady. And
6 there was evidence of use of a belt without any reason.

7 There was also the evidence of sexual abuse, at
8 least in relation to Dunclutha, both a residential
9 worker was mentioned and a gardener or handyman, and
10 then there was plainly the very concerning evidence
11 referred to by Mr MacAulay KC this morning regarding
12 sexual abuse via the local submarine base and I hear
13 what he says this morning about that, under reference to
14 the evidence of 'Peter' on Day 569.

15 At paragraph 11, my Lady, I've gone on to try rather
16 than -- rather than try to then list specific other
17 incidents, to try to draw out the range of abuse that is
18 alleged and given evidence to by applicants and I won't
19 read that out. I think it's, as your Ladyship will see,
20 already been drawn out by Mr MacAulay this morning and,
21 indeed, by Ms McCall, on behalf of INCAS, who mentioned
22 a number of the matters covered within paragraph 11.

23 At paragraph 12 though, my Lady, the overriding
24 sense -- and this is important -- the overriding sense
25 from many of the applicants was the fear that they

1 suffered under within these homes. And given that these
2 were children who needed local authority children's
3 homes because they were often vulnerable, and that the
4 purpose of them spending time there was for them to be
5 cared for, the fact that they were living under fear is
6 incredibly difficult for the current management of
7 Glasgow City Council to hear, my Lady.

8 I make the point at paragraph 13, as I've done in
9 the past, my Lady, that again the evidence in relation
10 to the applicants was not in relation to the care home
11 solely negative. Some applicants spoke to positive
12 experiences. However, again as with previous phases, in
13 the context of this Inquiry, those positive experiences
14 tend only to show, as I would have it, that those
15 positive experiences show it was perfectly possible to
16 do this well, it's just that it wasn't done.

17 If I can turn then to paragraph 50, my Lady, and in
18 relation to Fornethy House. As the council has set out
19 in detail prior to the evidence, those who attended
20 Fornethy were not in care within the meaning that that
21 term has in the social work legislation.

22 That is of course, and I want to make this palpably
23 clear, that is, of course, not to deny that they were at
24 the material time being cared for by the council and its
25 employees and it's not to deny that the council owed

1 duties to those at Fornethy. It is purely because 'in
2 care', in this context, has a particular meaning and
3 it's important not to confuse, with the social work
4 function, the school operated under the educational
5 function.

6 LADY SMITH: Yes. I mean, to put it as its simplest, none
7 of the children I've heard about had done anything wrong
8 that ended up with them going to Fornethy, not at all.
9 Those weren't the sorts of circumstances we're talking
10 about here.

11 MR PUGH: No. I think I'm coming on to address exactly that
12 point, my Lady.

13 The evidence in relation to Fornethy was of children
14 either being selected to attend because, for example,
15 they might have a single parent who needed time to
16 study, was one example, or because it might have been
17 thought that the single parent needed a break. In other
18 words, girls appear to have been selected for ostensibly
19 well-meaning reasons. Others, it seems, asked to go,
20 perhaps because a friend had been offered a place and
21 had had a positive experience at another similar place
22 in the past.

23 Early descriptions referred to in the council's
24 Section 21 response speak about convalescence and whilst
25 it's a matter for this Inquiry, that does not appear to

1 have been the explanation for most of the applicants who
2 gave evidence of their attendance and I think that's the
3 point in my submissions that Mr MacAulay was referring
4 to.

5 LADY SMITH: I don't think we have any of the many
6 applicants we had saying that they were there for
7 convalescence of any sort, not at all. And, of course,
8 our evidence from applicants goes back to the 1950s and
9 we actually span quite a number of decades of the
10 children going to Fornethy and it wasn't because they'd
11 been ill and needed to recuperate, not at all.

12 MR PUGH: No. I certainly wasn't aware of that being
13 a feature of any of the applicants' evidence.

14 LADY SMITH: And of course, it was called a residential
15 school, Fornethy Residential School. It was under the
16 auspices of the education department of each authority,
17 corporation and the regional council and the city
18 council.

19 MR PUGH: Indeed. It's hard and this was a matter -- the
20 council's email of 7 May 2026 to the Inquiry tried to
21 help to set out what, if you look through the
22 legislation, was the function of Fornethy and that was
23 certainly the closest that I could get to understanding
24 how, through the legislation, one could understand the
25 function of Fornethy as a residential school.

1 LADY SMITH: Yes. Thank you.

2 MR PUGH: Now, generally in relation to Fornethy, the
3 evidence appears to have been of children looking
4 forward to being away. That's not to deny, my Lady, the
5 trepidation that some young children might have felt
6 travelling without their parents, as seems to have been
7 the routine, but the expectation, and this will
8 undoubtedly have rung true with your Ladyship, the
9 expectation appears to have been that these children
10 were going somewhere pleasurable.

11 However, the applicants' evidence of their time at
12 Fornethy was uniformly bleak. Applicants described what
13 can only be called a cruel regime, participated in by
14 all staff members. Features of the regime included
15 cruel and unjustified punishments, cruel and undignified
16 practices in relation to bathing, force-feeding, long
17 walks in inappropriate footwear that caused injury and
18 forcing children to write letters that essentially
19 covered up the abuse being perpetrated.

20 The applicants spoke essentially of no positive
21 aspects of their stay, and frankly, my Lady, the reasons
22 for such a cruel regime are impossible to fathom.
23 Punishments appear to have been severe with no cause or
24 in response to the most -- no cause at all, or in
25 response to the most minor infractions, amounting to no

1 more than simply being a child. What was described was
2 essentially gratuitous cruelty.

3 I'll read short paragraph 19, which is essentially
4 just drawing the distinction between the functions of
5 these institutions and as between the care homes and
6 residential establishments and Fornethy.

7 At paragraph 20 though, the Inquiry heard a complete
8 denial by Patricia Robertson of any abuse or abusive
9 regime. Whilst she cannot recollect individually the
10 girls who stayed at Fornethy, her evidence was simply
11 that she had not abused any girl in the way described,
12 either in the evidence in this Inquiry or in her
13 indictment.

14 Notwithstanding, my Lady, Patricia Robertson has
15 been convicted on an indictment containing multiple
16 counts of abuse, having given, as was made clear when
17 she gave evidence, evidence on her own behalf and as was
18 referred to by Mr MacAulay this morning.

19 LADY SMITH: And the evidence included the evidence of
20 a colleague who worked at Fornethy when she was there.

21 MR PUGH: That's my understanding, my Lady. I don't think
22 we had that, but there was certainly reference to it
23 having been given.

24 LADY SMITH: Yes.

25 MR PUGH: At the outset of this phase, I indicated on the

1 council's behalf that it understood that this was not
2 the forum in which to litigate these matters and it
3 stands by that. It will be for the Inquiry to consider
4 Patricia Robertson's evidence when it comes to
5 performing its fact-finding function. It will do so,
6 however, having regard to the evidence of applicants,
7 both where there's clear and specific evidence and where
8 there's been perhaps slightly poorer recollection.

9 However, it's right to acknowledge that, at the very
10 least, the conviction of Mrs Robertson demonstrates that
11 abuse occurred at Fornethy. That was, as with other
12 institutions with which the council has been concerned,
13 acknowledged by Susanne Millar when she gave evidence.

14 And then, in relation to Fornethy, my Lady, I say at
15 paragraph 22 in relation to the descriptions of abuse
16 given by applicants, their evidence reflected at least
17 two further very specific concerns and I'll come on to
18 these in a little bit more detail; lack of records is
19 the first and second is access to the Redress Scheme and
20 I will return to those in a moment.

21 Regarding the lack of records though, I do just
22 publicly want to say what I say right at the end of
23 paragraph 22, my Lady, which is that, for the avoidance
24 of doubt, the council would not seek to argue that
25 records are likely to have recorded the abuse which the

1 applicants have described. Experience across all of
2 the fora, certainly in which I have dealt with these
3 matters and undoubtedly that your Ladyship has dealt
4 with these matters, shows that that's unlikely to have
5 been the case and I just want to publicly acknowledge
6 that.

7 LADY SMITH: Thank you.

8 MR PUGH: My Lady, I'm conscious that the time is 4 o'clock.

9 I have about five minutes. I'm happy to keep on or --

10 LADY SMITH: If you could just carry on at the moment, thank
11 you, Mr Pugh.

12 MR PUGH: In relation to the key themes that come from all
13 of that, again it struck me that many of those were the
14 same as had appeared in Phase 8 of this Inquiry and
15 I've listed those as being restraint, training and
16 policies, complaint handling, provision of education.
17 The fifth of those themes in Phase 8 was horseplay and
18 that wasn't really a feature of this one but the rest
19 I think really did show again in almost the same way in
20 many respects.

21 Of the matters that were raised as key themes in
22 Phase 8, there was again clearly evidence, and
23 particularly in relation to Fornethy House, of a lack of
24 training. Patricia Robertson spoke of being recruited
25 to Fornethy as a teacher and having worked in a school

1 in West Lothian. She spoke of no additional training
2 being given when she joined Fornethy, despite the clear
3 implication being that her responsibilities at Fornethy
4 would cover a much wider range of childcare than would
5 arise in a classroom setting. There is, we suggest, no
6 basis upon which to query her evidence on that issue.
7 Fornethy also, as we have explained, shows a return to
8 a lack of education and I'll come back to that.

9 With regard to policies and complaint handling, the
10 evidence of the approach within Eversley House to
11 complaints regarding John Marshall again showed
12 an obvious problem where (a) complaints were not fully
13 investigated and (b) where staff members have
14 inappropriately close relationships with each other.

15 In that regard, the Inquiry will recall that
16 a significant finding within the Frizzell Inquiry
17 regarding Kerelaw was that that culture had been allowed
18 to develop because the staff body had come from a very
19 close-knit community where it was difficult to speak
20 out, and in Eversley, the same problem appears to have
21 arisen due to the proximity of the relationship between
22 **SNR-RLD** and Mr Marshall, them later having married.

23 And at 26, I make the point again that I made at the
24 close of Phase 8, which is, and it's been made already
25 today, that the culture nowadays within children's

1 houses run by Glasgow City Council simply bears no
2 resemblance to any of the matters that are addressed
3 within there.

4 And on the particular issue of the proximity between
5 Mr Marshall and his wife, Ms Millar explained that such
6 a relationship would now have to be disclosed and the
7 council would ensure that those in a close relationship
8 work separately from each other. Worthy of note,
9 my Lady.

10 But in relation to the two themes being records and
11 inspection regimes, that arose from this phase and that
12 I didn't address at the close of Phase 8, if I can just
13 deal with those. The availability of records has been
14 a theme of every phase of this Inquiry in which this
15 council has participated, but in relation to Fornethy,
16 that problem has been -- I can only put it as
17 accelerated, I suppose, in the sense that there simply
18 is almost nothing.

19 Just from the top of page 10, the council is fully
20 aware that where records are not available, that leads
21 many people to its own frustration and can, at times,
22 create real concern beyond and independent of the
23 historical events themselves.

24 In the Foster Care phase of this Inquiry, it was
25 heard the efforts that social workers now go to, to

1 undertake what was determined 'life story work'. That
2 work recognises, my Lady, the need for people as adults
3 to have a record of what happened to them as children
4 and that need emphasises, we suggest, the hole that
5 might be created by an absence of those records.

6 Whilst the legal requirements for retention as
7 between social work or education records are for good
8 reason different, the evidence concerning Fornethy House
9 has shown that a different approach to Fornethy House
10 and records would have undoubtedly have been preferable.

11 As the Inquiry heard, the requirements applicable to
12 Fornethy appear to have been that when a child was at
13 Fornethy, they were, in fact, to be marked as present at
14 their home school. The result, as your Ladyship
15 observed during the evidence, is a fiction. Even
16 without focusing on the historical aspects of that
17 approach, it's plainly not conducive to the health and
18 safety of children to be recorded as being in a place
19 where they are not.

20 LADY SMITH: Where they are not, indeed.

21 MR PUGH: And I would just make the observation that the
22 evidence of Patricia Robertson, even if it's not
23 accepted in other respects, doesn't go far in helping us
24 to understand what might have been recorded at Fornethy.
25 She didn't really recall recording anything she and

1 others may have done, she didn't know.

2 The one fact that your Ladyship might draw from her
3 evidence was that it appeared to be the case that she
4 had a basic list of the children that she was dealing
5 with, with some personal information which might show
6 that there was at least some registration document
7 available to the teachers at Fornethy House. We don't
8 know, but certainly your Ladyship may draw an inference
9 from that evidence.

10 LADY SMITH: And according to Emma Fossey's report, there
11 were meant to be records, and records that would go from
12 the Glasgow school to Fornethy, falling into three
13 different categories, including the child's progress,
14 the child's educational progress whilst at Fornethy,
15 including something referred to loosely as the, I think,
16 'the camp register', similar to if a child is away on
17 a school trip, so you still record them, that must be
18 the recording them at Glasgow or within the Glasgow
19 schools ambit. Very strange.

20 MR PUGH: Incredibly difficult to track through anything in
21 relation to what was happening to records. And as the
22 point's been made, whether that's because it wasn't done
23 or whether that's because the records are not
24 maintained, we simply can't know.

25 LADY SMITH: Yes.

1 MR PUGH: Neither of those things is a terribly satisfactory
2 position for your Ladyship having to look at this so far
3 down the line.

4 LADY SMITH: And another aspect of what Emma Fossey had
5 uncovered, I think, was that not only were records
6 falling into these categories supposed to have gone
7 Glasgow to Fornethy, when the child was going back to
8 Glasgow, they were supposed to have gone back to
9 Glasgow, so that may well be where the records ended up
10 sitting, and then, particularly with the changes in
11 local authorities that happened, they've been destroyed,
12 lost, whatever, misfiled.

13 MR PUGH: Indeed. It's simply impossible, in my submission,
14 to know.

15 LADY SMITH: Yes.

16 MR PUGH: And I've made the point, just at the bottom of
17 page 10, that even with those caveats, and with that
18 discussion, my Lady, that more should have been
19 retained, it seems, than has been in the sense that the
20 logbooks should, at least for historical reasons, have
21 gone into the archive and that doesn't seem to be the
22 case.

23 My Lady, I have, in the weeks since these were
24 prepared, been able to speak to the council about
25 record-keeping within the education function and what

1 I can say is that electronic records now are available
2 of certain matters within something called the SEEMiS
3 system which does go back, not to the days of Fornethy,
4 but for people who have been through the authority in
5 the last 20 years, would have some information. That
6 system is about to be changed, but discussions are
7 ongoing to make sure that that legacy information can be
8 stored in accordance with data protection policies, that
9 that legacy information can be taken across. So there
10 is at least, I think, some reassurance that the
11 situation where there's simply no record of something is
12 at least less of a possibility than Fornethy has shown.

13 LADY SMITH: But that only goes back 20 years.

14 MR PUGH: Yeah, and it doesn't -- the council have searched,
15 I think, everywhere.

16 LADY SMITH: Thank you.

17 MR PUGH: I always hesitate to be as definite as that, my
18 Lady, but I think everywhere for anything that would go
19 as far back as Fornethy.

20 LADY SMITH: Thank you.

21 MR PUGH: And then in relation to inspection regimes, that
22 was another matter that was obviously thrown into light
23 by the Fornethy evidence and an obvious gap demonstrated
24 by Fornethy is the lack of an appropriate inspection
25 regime for that institution. Whilst the school operated

1 under the education function, searches have disclosed
2 that it did not have a registration number, as would be
3 expected of any school and the result seems to be that
4 the facility never fell under the appropriate regime for
5 educational inspection.

6 There's some evidence of some visits to Fornethy,
7 but with almost no detail and certainly with no
8 indication that they were regular. One example was
9 a visit in February 1989 to be conducted by the Director
10 of Education, and a Dr Green, and again, for what it's
11 worth, Mrs Robertson's evidence certainly didn't point
12 to any regular inspection. At most, it seemed that
13 there might have been some visitors from time to time
14 seemed to be the tenor of her recollection.

15 I've made the point here, my Lady, that the
16 council's education department now operates two
17 facilities that show the change in approach since
18 Fornethy. There's Blairvadach Residential Centre and
19 Knightswood School of Dance. In relation to the school
20 of dance, for example, in relation to the residential
21 aspect, houseparents must be SSSC registered and the
22 facility is to be subject of inspection by the
23 Care Inspectorate.

24 Pupils attend at Knightswood Secondary School where
25 staff are fully trained in the council's child

1 protection policy and which, for obvious reasons, is
2 itself subject to HMIE inspection. And in relation to
3 Blairvadach, pupils attend the outdoor centre with their
4 own school teachers, who remain with them throughout
5 their stay, I imagine similar to most of the camps that
6 we send our children to these days. And who are all
7 trained in terms of the council's child protection
8 policies. The centre's activities themselves are
9 inspected by the Health and Safety Executive and certain
10 activity specific bodies.

11 For the children's homes, as would be expected,
12 there's better evidence of inspection. For example, in
13 relation to Eversley, there's a file showing the
14 independent inspections that were carried out at that
15 facility and it's unclear why other inspection files do
16 not exist for the other homes, my Lady.

17 And I finish on that, in relation to the inspection,
18 the positive note that as the Inquiry saw, the council
19 set up an inspection unit in the 1990s, which I think as
20 we all understand, is a period where local authorities
21 were getting to grips with the need to listen to
22 children and these other matters that we've discussed in
23 the past.

24 That inspection unit was responsible, amongst other
25 things, for the inspection of Park Lodge in 1996, which

1 identified some of the problems within that home and
2 Susanne Millar was asked, when she gave evidence, how
3 that unit was viewed. Ms Millar indicated that they
4 were well-regarded and credible. She considered them to
5 have been child-centred in their approach and that's
6 shown, in my submission, by the fact that they were
7 willing to criticise the situation at Park Lodge and
8 that demonstrates that independence.

9 It's not known precisely what happened following the
10 inspection of Park Lodge and I plainly see the
11 difficulty with relying on it too heavily for that
12 reason, my Lady, but at least insofar as the ability to
13 inspect their own facilities, that shows a positive step
14 forward in the 1990s.

15 My Lady, I finish with the point about Redress
16 Scotland, which was -- I know it's not within the scope
17 of this Inquiry, but I make the point simply because
18 it's so important to those who were resident at
19 Fornethy.

20 LADY SMITH: You say it's not within, but the impact
21 caused --

22 MR PUGH: Of course.

23 LADY SMITH: -- to people who were in care, in residential
24 care, is within and it's absolutely plain that what the
25 Fornethy survivors feel is rejection where it's not fair

1 and where they are being treated as having a lesser form
2 of abuse than others is -- has had and is having
3 a seriously detrimental impact on them.

4 So I don't have a problem with impact being within
5 the Terms of Reference under which I'm operating and the
6 very real likelihood that I can conclude that the impact
7 to the Fornethy women comes within that insofar as it
8 applies to them being denied redress.

9 MR PUGH: Plainly, it's your Ladyship's Inquiry --

10 LADY SMITH: Well, I'm happy to say that at this stage.

11 MR PUGH: But certainly, from my perspective, I address it
12 because it's come up so plainly from the evidence of
13 applicants from Fornethy.

14 LADY SMITH: Yes. Yes.

15 MR PUGH: And the point I draw in the written submission,
16 and that I make to your Ladyship today, is your Ladyship
17 heard, when 'Julie' gave evidence, that there had been
18 petitions to the Scottish Parliament and -- about the
19 extension of the Redress Scheme. And it was said then,
20 correctly, that Glasgow had responded to those petitions
21 and I've set out there the terms of Glasgow's response
22 just so that the Inquiry can understand what that is.

23 LADY SMITH: Thank you.

24 MR PUGH: And, in particular, the reference in the middle of
25 that response:

1 'I can say that GCC would not be opposed in
2 principle to extending the scheme to allow those who
3 attended Fornethy House to make applications to the
4 Redress Scheme.'

5 And that, my Lady, that remains the council's
6 position, although they have no control over the terms
7 of the scheme. So I make that point just for
8 completeness essentially, my Lady.

9 Unless there's anything else arising, then those are
10 the submissions for Glasgow City Council.

11 LADY SMITH: I have nothing else at moment.

12 Thank you very much, Mr Pugh.

13 Well, I'm going to stop there for today and we'll
14 return to closing submissions tomorrow morning.
15 According to my list, we have four still to go and
16 that's from the Care Inspectorate, the Chief Constable
17 Police Scotland, the Lord Advocate and Scottish
18 Ministers.

19 I'll sit at 10 o'clock and I look forward to hearing
20 those submissions tomorrow.

21 Thank you.

22 (4.16 pm)

23 (The Inquiry adjourned until 10.00 am
24 on Friday, 19 June 2026)

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