Scottish Child Abuse Inquiry

Witness Statement of

John MULDOON

Support person present: N/A.

1. My name is John Penman Muldoon. My date of birth is [redacted] 1953. My contact details are known to the Inquiry.

Background

2. I have an HNC in Social Care, which was a 2-year course. I also have SVQ III and SVQ IV qualifications. I was a trainer for T.C.I and I was an HNC Tutor and workplace assessor.

3. I was employed at Kerelaw School from 1982 or 1983 and I worked in both the secure unit and the open school there. I worked with young people for twenty-five years.

Kerelaw School

4. Kerelaw School was in Stevenston, Ayrshire and it was a residential unit. My first impressions were that it was a large establishment.

5. In hindsight, I would describe Kerelaw as a strict but caring establishment. Both the attitude of staff towards children, and the relationship which existed between staff and children, was professional and caring.

Time at Kerelaw School

6. I was a night care officer. A care worker and ultimately a unit manager.

7. The process followed when I was recruited was dealt with by GCC (Glasgow City Council) personnel department.

8. My line manager when I was in the secure unit was LEF [redacted]. There was daily liaison in addition to formal supervision. My line manager when I was in the open school was KAB [redacted]. Again, there was daily liaison in addition to formal supervision.

9. Training was wide and various. It was both formal and informal and it was on a continual basis.

Structure and recruitment of staff

10. There were both day and night care officers, a deputy manager, a unit manager, three deputy heads and a head of establishment.

11. The head of the establishment was in charge and worked with an open-door policy.

12. I was not involved in the recruitment of staff, that was handled by GCC personnel department. I cannot provide any information as to recruitment policy and recruitment practices.

13. Volunteers also worked at Kerelaw. They were recruited by the deputy head and reported to her.

14. I cannot comment on the extent to which references were obtained, what a reference was expected to cover, nor whether referees were actually spoken to.

15. As a unit manager I was in charge of approximately ten care officers and one deputy manager. I held formal supervision sessions, which were formally recorded and held on file.

Training

16. As a unit manager I was involved in the training and personal development of staff.

17. Training was done both formally and informally. As unit manager, you would see the practices of others on a daily basis and you would record both good and bad practices as they happened. You would address them either as they happened, or in formal supervision. Any worrying practices would be discussed with the deputy head who was my line manager.

18. Training and personal development policies were issued by GCC. Personal development was implemented by my line manager through both daily discussion and formal supervision.

Supervision/ appraisal/ evaluation

19. As a unit manager, I was involved in supervision of staff, staff appraisal and staff evaluation.

20. Formal supervision was conducted by me. This was recorded and signed by both parties and any disputes were passed to the deputy head for conclusion.

21. I cannot comment on the institution's policy in relation to supervision of staff, staff appraisal or staff evaluation.

22. It would be the responsibility of all staff to supervise any volunteer on the premises. That supervision would be recorded in the unit diary, the unit logs and the young person's files. As with all staff, that was the nature and extent of my involvement too.

Policy

23. All policy documentation was the responsibility of GCC personnel department and was passed to the staff at Kerelaw to implement.

24. Obviously, policy changed over time. The timing of such changes escapes my memory, but what I do remember was that record-keeping on all subjects was numerous and substantial. Any discipline or punishment of a young person would be recorded in the daily log and the young person's individual file and both the parents and the young person's social worker would be informed. This would again be recorded and time dated.

25. Any pupil/staff complaints would be handed over immediately to the appropriate social work department to be investigated formally.

26. Discipline of staff would be conducted by GCC, outwith Kerelaw.

Strategic planning

27. I did not have any involvement in, or responsibility for, strategic planning in relation to Kerelaw. I cannot provide any information about the strategic approach.

Children

28. Children were placed at Kerelaw following court orders, Children's Hearings, instruction from GCC on an emergency basis and from police custody.

29. The length of time children tended to stay at Kerelaw would depend on each individual's needs. Approximately, it would be between six months and two years.

30. All dates are approximate, but when I first started in 1982/1983, there could be approximately twenty-six boys in each unit and there were four units, all boys. Girls were introduced in 1988 or 1989 to two units and each unit held fourteen. The age range was approximately thirteen years to sixteen years and over, although the norm was fifteen to seventeen years old.

31. How long a child tended to stay in Kerelaw depended on individual care plans and whether follow-on placements were available.

32. There were normally four staff on duty at any given time, although the unit manager, the deputy manager, social work visitors, parents, kitchen staff and visiting panel members could also be there.

33. Food, in my opinion, was more than adequate. If any young person had individual dietary needs, they would be catered for.

34. In 1983 there were four children to a room. This changed to two per room and there were also some single rooms, but very few.

35. There were communal shower areas in 1983 and individual showers and a separate bath from approximately 1988. There was a laundry that was separate from the units and from approximately 1990 there were individual washing machines in each unit.

36. How children spent their leisure time was by mutual consent. They would ask to go to the pictures, or ice skating, etc.

37. All trips were organised and recorded in unit logs: the unit diary and the young person's individual file. Holidays would be with the consent of the individual's family and social work department. Formal consent forms would have to be signed off and GCC would also have to give consent.

38. All trips, whether formal or informal, would be authorised by the senior management and recorded in unit logs, the unit diary and the young person's individual file. As part of an outing, the possibility of an individual dropping into their home was not encouraged, although I have been told it did happen.

39. The children were schooled in a separate building on the campus.

40. All young persons had individual 'R.I.C. 3' cards and were registered with the local G.P.

41. The children did not do manual work.

42. Parents, family and others did visit the children. All visitors, including parents, were vetted by their social workers and would be part of a young person's care plan and authorised by the Children's Hearing system. They could take the young person out if it was part of their care plan and organised.

43. All the young people's social workers visited, some more than others. During their visits they would be allocated a room for private discussions. Others would take their clients outwith the school. It would depend on each social worker, but both options were available. The individual social work department would provide reports and they would be responsible for their safekeeping. School staff would also provide reports and they would be responsible.

44. The young person's Children's Hearing system would call a review every three months and they would collect all reports, including the young person's own report. The Hearing system would be responsible for the safekeeping and recording of those reports. All these reports would be kept on file within the individual's social work department. All of the above would be responsible for the implementation of recommendations. Drug workers or any other outside agency would also forward reports and would be responsible for their safekeeping.

45. School reviews would be held every three months. All parties connected with the young person would submit a review report. Parents were also expected to attend. The Children's Hearing system would call reviews and they would be held at their premises.

46. Discharge was the remit of the young person's social work department throughcare team, based in Glasgow. The school would help with the process but had no direct authority.

47. Once the young person left the school, the responsibility for their wellbeing was passed to the local authority. Kerelaw was in Ayrshire and most young people stayed in Glasgow. We had neither the staff, nor the resources to help.

48. Prior to leaving, the young person's care worker would have a major role in preparing them for moving on. They would attend meetings with them outwith the school, but once they physically left the school, the order would be changed from a 44(1)(b) by the Children's Hearing system to whatever order was suitable for their circumstances.

Living arrangements

49. I stayed approximately seven miles away from Kerelaw, in my own private premises.

50. The only people that stayed within the boundaries of the school were Jim Hunter, the headmaster, but that was only for a short period of time until his private home was finished. He stayed at [redacted]. KAB [redacted], SNR [redacted] stayed overnight on a regular basis because where she lived was a distance away and she worked late shifts and started early. She, in my opinion, was the most dedicated of all the senior staff. KBU [redacted] stayed in [redacted] with his family. Jack Stocker stayed for a short period in the same houses. LYW [redacted] LYW [redacted] also stayed in [redacted] with his family.

51. All staff members had access to the children's residential areas. Visitors would be registered both in and out by admin staff for fire safety reasons.

52. Night care officers and senior staff on call were responsible for the children's residential areas overnight.

Discipline and punishment

53. There was no physical punishment of children. A staff meeting would be held and each young person would be discussed. It would be a joint decision as to any loss of privileges and social workers and parents would be informed.

54. There was a formal policy and code of conduct in relation to discipline and punishment.

55. Staff were aware of the policy because they all signed a code of conduct policy as part of their contract. Additionally, through weekly unit meetings and training, alongside working with their colleagues, staff would be aware of the day-to-day workings of the unit. Young people were given a copy of the rules and expectations of day-to-day living within the unit and there was also a copy on a notice board within the unit.

56. There were no expectations on senior residents to apply sanctions, although the older, quieter residents would prefer a more peaceful unit and would frown upon the rowdier youngsters.

57. A Friday leave would be earned, however all other leave on a Saturday and Sunday could not be refused. The type of behaviour that resulted in discipline or punishment included absconding from the unit, involvement in criminal behaviour and fighting. More minor behavioural problems could result in a loss of recreational trips.

58. How discipline was administered for things that were not permitted would be discussed by all staff on a weekly basis and parents and social workers would be informed.

59. The young person's care worker would mostly administer discipline to them.

60. Discipline took the form of a loss of Friday leave and a loss of recreational trips.

61. Children were not physically disciplined or punished.

62. As a care worker I did discipline children and as a unit manager I did so on occasions. As I have stated, any discipline was a joint decision and discussed by all staff on a weekly basis. These meetings were minuted in the unit log and also in the young person's individual files and the social work department and parents were notified.

63. A record was kept of when children were disciplined or punished. A separate book was kept for more serious incidents, i.e. assaults or self-harm. All discipline issues were logged in the young person's individual file, the unit daily log book and the unit staff weekly meeting book. All social workers and parents would be informed and that would be logged in the monthly log book. Each young person would be discussed as part of their formal supervision and logged. Any young person giving concern would also be discussed at senior management meetings, which were held weekly.

64. The purpose of recording in such detail was supposedly to protect both the young persons and the staff.

Restraint

65. Restraint was used on children during my time at Kerelaw.

66. If a young person was out of control and was a risk to themselves or others, restraint would be done by trained staff members and would consist of at least two staff using T.C.I. (Therapeutic Crisis Intervention).

67. I did restrain children. I, along with others and never alone, have had to restrain young people who were out of control and endangering themselves. All restraints were either within the unit or within the school.

68. In 1982/1983 there was no policy that I was aware of for restraint. I was aware I had the same rights as any person to defend myself if assaulted.

69. I was sent on a training course held at Gartnavel Hospital by my employers. This course was presented by two male and one female instructors, who were all black-belt

karate experts. They informed me that this course was also taught to police and prison warders.

70. The course itself consisted of the manipulation of limbs (arms or legs held against the joint) as a way of immobilising and bringing the person under control. At the end of this, we were informed that if a restraint was needed, no practice other than what we had been taught would be accepted.

71. In approximately 1991, the introduction of T.C.I. was implemented and over a number of years all staff were trained. This was more about de-escalating of situations, but it did also have a physical element. The T.C.I. policy also consisted of a record of the actual restraint from start to finish. This document would be signed off by senior staff and if any problems were identified, they would be highlighted and dealt with. As a further safeguard, this document would then be sent to Bill Adams at Glasgow for further scrutiny.

72. I witnessed a lot of restraints in my time at Kerelaw as it was the rule that the senior officer on duty would have to attend all restraints. It was my duty to attend and observe and comment on the appropriate forms. All restraints were terrible to witness, regardless of experience, but it was essential to keep the young person safe, if they were out of control.

Concerns about Kerelaw

73. I had no knowledge of any concerns within Kerelaw itself or to any external body or agency, or any other person, because of the way in which children and young people were treated.

Reporting of complaints/concerns

74. If a complaint was made, the young person's keyworker would help that young person fill the appropriate form in. What was more likely to happen was for the young person to phone their social worker to deal with their complaint. These complaints would be

recorded in the young person's own file, the unit log, the unit diary and in a separate complaints book.

75. 'Who Cares' were also present and spoke to all young persons in private.

76. H.M.I. also on various occasions inspected the school and would talk to the young persons as part of their inspection. They also worked shifts, including nights, along with the unit staff.

77. I never received any complaints of abuse in regard to staff.

78. Complaints were recorded in the young person's file, the unit log and the unit diary. Social work would be informed and there was a separate complaints book.

Trusted adult/confidante

79. There were people in Kerelaw that children could speak to about any worries they had.

80. All young people had a keyworker. Who Cares visited on a regular basis and there was also the young person's social worker, or at review meetings, or at Children's Hearings. They could also speak to any staff members, including any of the domestics. There were weekly young people meetings that were minuted by them and had a separate agenda from the working of the unit. There were also H.M.I. inspectors, the young person's parents, their doctor, psychologist, or they could speak to each other.

81. I'm sure there would have been plenty of young persons making complaints and that is why the record keeping was of such a high standard, duplicated to the extreme and inspected by H.M.I., etc.

82. Over a long period of time, various complaints, some trivial, some more serious, would be given to me. At all times I would use the procedures available at that time. All were

carefully recorded and passed to social workers or senior staff and parents were informed.

Abuse

83. All staff signed a code of practice document, which covered the expectations of good practice towards the clients. Before signing this document, all staff were expected to carefully read and understand what was expected of them.

84. Along with the code of practice document, various courses on child protection were offered. The HNC, SVQ and other social work training courses cover the topic of abuse of children in care.

85. All clients were expected to be looked after appropriately. All young people were registered with the local G.P. and a dentist. On admission, a young person was given an admission medical, which was entered into a R.I.C. 3 book. This book covered checking for bruising, self-harm scars, or anything unusual on the young person's body. This would also happen when a young person left the establishment.

86. I witnessed no sexual abuse in my twenty-five years of work with young people, either girls or boys.

87. There were a few young people over the years who reported sexual abuse by people outwith the school to me. After they did, I immediately implemented child protection procedures.

88. I am confident that if any child was being abused or ill-treated, it would have come to light at or around the time it was occurring, given the nature and age group of the young people in our care, who had multiple placements before arriving at Kerelaw, and the number of young people who were held in a confined space. I am confident because of the gossip that existed amongst the young people and the fact that nothing happened in Kerelaw without everyone knowing about it.

89. Abuse during my time at Kerelaw could not have happened and gone undetected. There were numerous people coming and going within the units and because of the fact that no-one worked alone. Also because of the amount of people both living and working within such a limited space. Additionally, there were all the professional bodies, H.M.I., field social workers, psychologists, etc., who interviewed young people without interference from staff. These people were specifically trained to identify abuse of all kinds.

Child protection arrangements

90. All staff members signed a code of practice conduct document. This was issued by Glasgow City Council with all the guidance and expectations of the environment. Each unit had written documentation that was discussed at staff meetings and training days. This documentation was forwarded to H.M.I. for inspection.

91. All forms of abuse would be forwarded to senior staff along with the relevant social work department being notified. No complaints or reports of complaints would be investigated by the school. The relevant social work department would conduct the investigations of complaints independently. There would be times when the social work department for the complainer would ask the unit manager to hold the investigation, but that would only be for minor complaints.

92. There were strict guidelines for complaints. All social work departments would be notified immediately along with senior staff. There was no discretion.

93. The child protection arrangements that were in place to reduce the likelihood of abuse included: no staff worked alone; any one-to-one workings were carefully recorded; training through various means was available; each unit had a standard procedures document and all this documentation was inspected by H.M.I.

94. My thoughts on whether such arrangements worked would be that nothing was perfect and staff worked under extreme pressures and expectations.

External monitoring

95. H.M.I. inspections were both announced and unannounced. They would spend up to a week on an inspection at times, sometimes more. In addition, Glasgow councillors would visit and Children's Panel members were regular visitors.

96. H.M.I. would work shifts, including nights, and would speak to all young persons within the units, mostly on a one-to-one basis and separately from unit staff.

97. I spoke with the H.M.I. inspectors. Verbal feedback was given to me along with general questions regarding the running of the unit, before the formal report was issued.

Record keeping

98. Record keeping was of the utmost importance and was inspected on a weekly basis at unit meetings by me or the deputy. These meetings were agenda-led and record keeping was top of the agenda. Separate records were kept for any serious incidents and all departments were informed and senior staff were informed. All units were responsible for their own records and not only inspected by senior staff, but also by H.M.I. when they carried out inspections.

99. I knew of no other way of working as this system was in use when I started. H.M.I. reported back that in fact we were duplicating our record keeping and should cut back as it was producing too much paperwork.

Investigations into abuse – personal involvement

100. I do in fact remember attending a child protection meeting outwith school. This was held at the young person's social work department and I remember a doctor, a senior police officer, a psychologist, district officers and the head of department were all in attendance.

101. This had nothing to do with Kerelaw as it was an investigation into alleged abuse by parents towards their child.

Reports of abuse and civil claims

102. I have never been involved in the handling of reports to, or civil claims made against, Kerelaw by former residents, concerning historical abuse.

Police investigations/ criminal proceedings

103. I was not aware of police investigations into alleged abuse at Kerelaw when I worked there. It wasn't until after I left that allegations started.

104. I had left my employment by that time, so I had no knowledge of what happened.

105. I have given a 'no comment' statement to police.

106. I have given evidence at a trial concerning alleged abuse of children at Kerelaw. I was convicted in December 2022 at Glasgow High Court of numerous charges, including those of a sexual nature, all of which I denied then and continue to do so now.

Convicted abusers

107. There were no people who worked at Kerelaw who had been convicted of abuse as far as I know. All workers were police background checked and their references were checked before employment. When you applied for promoted posts you were automatically police checked again.

Leaving Kerelaw

108. I left Kerelaw because my contract was terminated by Glasgow City Council. No references were provided.

Helping the Inquiry

109. It would not matter what my thoughts were regarding how it can be that allegations of abuse have been made, as it is such an emotive subject. I would gladly submit to a polygraph and answer any questions regarding sexual abuse of any young person in my care.

110. In my view, the lessons that can be learned are that an automatic polygraph for both accusers and accused would be interesting. Also, police fishing expeditions should be stopped.

111. For the past twenty-or-so years, the government have broadcasted a commercial telling young people in care that they have laid by x-amount of money if they had been abused. I think it has been on Radio Clyde. The accusers phone records should be checked as they are openly discussing compensation payments with each other, for example "You get more money for sexual abuse than for assault".

112. Reports should not be destroyed and instead records should be kept for the lifetime of staff to help protect against any false accusations.

Applicant allegations

113. There was no physical punishment in my time at Kerelaw. Any sanctions on any young person were on a collective basis and carefully recorded in numerous logs. Social workers and parents would be informed. These sanctions would be a loss of privileges, for example no recreational trips or the loss of Friday leave.

114. I did not abuse children at Kerelaw.

115. My response to why the Inquiry has received evidence suggesting that I did abuse children, would be what I have already said under the 'Helping the Inquiry' section.

116. I do not accept that I or someone else abused any child.

Convictions

117. I have no way of supplying information as to my criminal convictions relating to the abuse of children as I am in prison and have no way of receiving this information and I hold no paperwork relating to my convictions. What I do know is that I was convicted in December 2022 at Glasgow High Court and sent to Barlinnie where I remain.

118. I had no convictions when I started, or at any time during my employment at Kerelaw.

Other information

119. Please note, all my answers have been from memory as I had no way to research anything.

120. I also attended in-person the Kerelaw Inquiry at the time. I attended with my wife and answered all questions put to me. This will be a matter of public record and could be helpful to you. I cannot remember when this happened.

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

Dated..... 5/4/'24 .....