Wednesday, 31 May 2023

(10.00 am)

Professor Ian Levitt (continued)

LADY SMITH: Good morning, and welcome back, Professor Levitt.

A. Good morning, my Lady.

LADY SMITH: If you're ready to start we'll just carry on. Is that all right?

A. Thank you.

LADY SMITH: Mr MacAulay.

Questions from Mr MacAulay (continued)

MR MACAULAY: My Lady.

Good morning, Professor. Yesterday afternoon, we had been looking at your final review of the independent special and grant-aided residential schools, and we're now moving on to page 143 of the report. We're looking at the section headed:

"Local Authority and independent residential schools."

A. That's correct.

Q. In this particular section, you look at a number of schools and the first of these is Merchiston Castle School, in Edinburgh.

A. Could I explain, first, that I tried very hard to find evidence relating to Local Authority Residential Schools

and, in fact, the only one that with sufficient information was Anderson High School, Lerwick, but I know there were other schools in the Highlands that offered residential accommodation.

Q. The Anderson School has a halls of residence set-up?

A. Yes.

LADY SMITH: So nothing on the hostels either; is that right?

A. No, not in this particular period.

LADY SMITH: Thank you.

A. It's simply a question of what records had been retained.

LADY SMITH: I can appreciate that. Thank you.

MR MACAULAY: But what you tell us, on page 144, is that in March 1996, under the provisions of the Education Scotland Act, Merchiston Castle School underwent a welfare of residential pupils inspection. Looking at matters like welfare and so on, I think the position is that there was a positive outcome?

A. Yes. It was clearly -- they felt that the school had moved on from any previous inspection. Although they provided advice in terms of looking for child protection guidance in terms of pupils' rights, equal opportunities, multi-cultural education and for personal and social education, and that their report would be

considered ahead of any future inspection.

Q. I think -- and we see this with other boarding schools -- the accommodation required some looking at?

A. That's right, yes, yes.

Q. You just mentioned a moment ago the Anderson High School in Lerwick. You look at that next, on page 145, and you explain the situation here is this was managed by Shetland Islands Council, which provided two halls of residence.

A. That's correct, yes.

Q. I think we have heard this before: this was an arrangement whereby children could not travel locally to a secondary school and, therefore, had to move further afield?

A. There are obviously some islands in Shetland Isles, I think Stromer is one where obviously pupils aged 11 would have to have residential accommodation if they were to have any education at all post-11.

Q. This is an HM Inspector of Schools inspection and, again, I think a positive result?

A. It was reasonably positive. The only concern they had was irresponsible behaviour by pupils at night, which is a nice way -- polite way of saying they were a bit rowdy.

Q. The Lathallan School in Montrose, again I think this is

an HM Inspector of Schools inspection, in 1999, and again looking at what you've set out there, a reasonably positive outcome?

A. Yes, in this particular example what I've tried do was also include a reference to the earlier inspection in 1991, to show the limitations of the inspection regime, which was concerned, really, with only pastoral care in a very rounded sense, rather than any deliberative child protection sense. And comparing that with the 1999 inspection.

Q. It's one page as against seven pages?

A. Yes. That's right, yes, yes.

Q. Then the next school to look at is Loretto School in Musselburgh, at paragraph 4.2.8. You give us some background about the school. I think what you tell us is that the inspection discovered accommodation problems?

A. Yes. I think the category "fair" indicates there were clearly some weaknesses in the quality of accommodation that was being provided, certainly for boys.

Q. Yes. I think we have seen that previously, where the boys' accommodation seems to be -- how shall I put it? Less salubrious than the girls'.

A. Yes.

Q. This inspection was in February and March 1999.

A. Yes.
Q. And found matters were very good or good in most areas, but apart from the accommodation.
A. That's right, yes, yes.
Q. There was a follow-up inspection and you address this at paragraph 4.2.11, in February 2000. What did this set up?
A. I think it's important to bring out the fact there was a follow-up inspection, which is relatively new post-1995.

If you look at earlier inspections, you had an inspection and that was it, really. There might not be an inspection, for instance at Donaldsons, the previous inspection to 1998 was in 1985 and that's quite a distance in terms of time.

So this is an indication in terms of a different kind of inspection regime post-1995. I really feel I need to bring that out. In terms of actual inspection regimes, you have: okay, there are weaknesses here, we need to follow it up.

And as you can see here, the school had made good progress in refurbishing the boarding houses, furniture, additional security measures, et cetera.

Q. Is this showing that the inspecting regime is having an impact?

A. Yes, yes. Clearly, having an impact, and it was certainly clear from the material that I read that the school was informed there would be a follow-up inspection at some stage.
Q. So there was some degree of inspiration for them, if you like, to get on with it?
A. That's right, yes, yes.
Q. And then, at 4.2.12, you look at Glenalmond College in Perthshire. In particular, an inspection in 1999, which found that the quality of the school's accommodation varied from very good to fair.
A. Yes.
Q. But the provision of accommodation in some of the boys' dormitories were particularly noticeable as having weaknesses?
A. That's right. The same issues emerging; spartan accommodation for the boys.
Q. You come back to Merchiston in the next section.
A. Yes.
Q. This was a full inspection in January 2000. That was the first, I think, since an inspection under the former regime?
A. That's right, yes.
Q. Is that one of the reasons you draw this out?
A. Yes, yes, yes. In particular, the change in the way

that the inspectors actually operated and the questions they asked, the questions they posed and who they spoke to as well.

Q. Leaving accommodation aside, so far as the rest of the findings are concerned; what did they report?

A. It reported that the school had a very clear child protection policy, with good staff development and procedures were well understood. Any incidents were fully reported, including incidents of bullying. And there was liaison between the houses and the medical care staff in relation to this.

Q. And in relation to accommodation?

A. The accommodation, they felt that that had still not been properly addressed, and some of the houses still remained major weaknesses.

But the issue, of course, as I say in 4.2.15, was that the regulations governing independent boarding schools hadn't really altered since 1959 and, in fact, the regulations were such that SOED Inspectorate could not really enforce any change at this time.

Q. Yes, but although the school may have slipped through the net in relation to standards for accommodation under the regulations, in fact the school; did the school meet that problem in a pragmatic way?

A. Yes, the school accepted the fact that the accommodation

did need to improve irrespective of the issue of the weakness of the regulations governing independent boarding schools.

Q. Here, again, I think you draw attention to the fact that there was a follow-up inspection in March 2020(sic) to 2002, and you address that at paragraph 4.2.18.

A. Yes.

Q. Had progress been made?

A. Yes. Progress had been made. But, as I say, another inspection occurred two years later, another full inspection.

The difference between a follow-up inspection and a full inspection, which is quite important to understand. The follow-up inspection was really seeking to establish whether or not the action points of the main inspection had been met and then, the following year -- in 2003, sorry -- a full inspection of care and welfare of the pupils was undertaken.

Q. In relation to pastoral care, and personal and social development; were the findings positive?

A. The findings seemed to be positive, yes, that everyone was familiar with the Child Protection Policy and implementing the procedures that followed. And that there was training undertaken in terms of child protection policies.

Q. In relation to refurbishment; was there an action plan --

A. There was an action plan for one of the residents which had not been refurbished. But that was in progress, and the school later confirmed that the refurbishment had taken place and security measures, the linked security measures, had been carried out.

Q. Yes. In a subsequent letter, that was confirmed.

A. Yes, yes, yes.

Q. Then, in your short review, at 4.2.21 onwards; what is your overall view here in relation to independent residential schools?

A. I think there was clearly a step change in the way that the HMI Inspectorate undertook inspections and they undertook inspections on the same basis as inspections of SEN schools; that irrespective of whatever school it was, the issues surrounded safeguarding of children and ensuring that child protection policies were being followed through. And that included, obviously, looking at the state of accommodation, the medical facilities that were being supplied and offered, and the training that staff undertook in terms of child protection.

Q. Do you see the picture here as being one overall that's positive? By that I mean that the schools have responded to criticisms.

A. The schools have responded to the criticisms. They may not have responded immediately, but within a few years they had met the action points that the Inspectorate had set out.

Q. Then your overall review, at 4.3; can you quickly just give me an overview of that?

A. Yes, sort of reiterating what I've said, that there was certainly a step change in attitude towards inspections over the period.

Clearly, the Raddery, Camphill and Oakbank schools heralded the beginning of new approaches to undertaking inspections of any form of residential school and it wasn't just a question of the quality of teaching or whether or not the accommodation, the actual building, was substandard, but making sure that appropriate child protection procedures, safeguarding, et cetera, were actually in place. And that staff were trained and that the -- you had available for pupils telephones that they could immediately phone for assistance and help and raise complaints.

I think, additionally, what's interesting to note is that the Board of Governors of these independent schools were brought into the frame as well, that they were all informed that they had certain responsibilities under law for ensuring that a school was registered and that

safeguarding was taking place.

LADY SMITH: I think the inspections also picked up that this was the era where boards of governors were beginning to appoint one of their number to have child protection responsibilities?

A. That's right.

LADY SMITH: Is that not right?

A. That's right. Speaking as an ex-school governor myself, I'm aware of the change that was occurring in this period. And, yes, a member of the board I was at -- there was someone who was designated responsible for child protection.

LADY SMITH: Thank you.

MR MACAULAY: I think we had seen in Donaldsons that the governors appeared to have been blissfully ignorant of their own legal duties.

A. Yes.

Q. That's been brought out --

A. That was clearly brought out that they had to be very careful in understanding the impact of the legislation on their own responsibilities, and they should be more proactive in managing the school.

Q. Your final conclusion then is: in all these considerations, whether it was special or other residential schools, the period 1992 to 2004 witnessed

a tightening of the inspections regime and a focus of establishing a child protection culture that pervaded contacts in these institutions.

A. Yes, the fact that you had follow-up inspections. If there were action points which deemed that an issue was fair, ie there were some important weaknesses, then there would be a follow-up inspection within 12 months.

Q. Then your overall review and conclusions in relation to this report, you begin looking at that at section 5, on page 154.

A. Yes.

Q. Can you just take us through that, if you would?

A. Yes. I mean, I think one doesn't want to say it's a false dawn, but you saw the creation of Inspectorate, but that Inspectorate over the period of time did not really have any further extended inspection duties other than sections in care and insecure accommodation.

They were certainly available to assist the Education Inspectorate in conducting inspections, but that was very much at the discretion of the Education Inspectorate and unless so deemed by the Ministers concerned.

So I think it's important to recognise that the Social Work Services Inspectorate was a name which did not necessarily lead to increased inspection of local

services.

Q. I think the point being that notwithstanding what the initial thinking may have been, they did not become involved in the inspection of the services, as opposed to the schools?

A. There was no inspection of the quality of Local Authority Social Services, no inspection of the quality and provision of any residential homes for children in this particular period; that was left to Local Authorities themselves to ensure their arm's length inspection units were operating properly.

And from what I can see, I can't see any evidence from the records that in fact advice was given on the conduct of those arm's length inspections. There might well have been, but I didn't see any regulations being formed or directions being given. I think I do mention in the main text that no directions were given on the conduct of arm's length inspection units.

Q. If you look at 5.4 -- perhaps just jump ahead to that -- here you have the reference to the 1995 Act, and you say "Undoubtedly reflected changes in public attitudes towards public services".

A. Yes.

Q. Is that right?

A. I think it was a period of time when the public

generally wanted to ensure that there were quality public services on offer and that the Government responded by -- within this Act -- enlarging the responsibilities of HMI Education to review the quality and provision in terms of safeguarding of children within residential schools.

Q. And at 5.6, I think you go back to the point I think we've discussed, when the death of a child who could not be admitted caused a problem.

A. Yes. Clearly, there was, in terms of actual demand, a shortage of secure accommodation. It was certainly a contentious issue in terms of contemporary professional opinion as to the amount of secure accommodation that was actually necessary at the time, but they had had ministerial direction that the sector should be expanded, and past 2000 you had another expansion particularly aimed at girls.

Q. At 5.7, as we have discussed, the publication of Another Kind of Home did have an important impact on standards.

A. Yes, I think the elaboration of thought subsequent to that publication indicated that any inspection of a residential accommodation, certainly secure accommodation we have seen, and also I think in residential schools, detailed more evidence, including logbooks, interviews with pupils, staff, social workers

and seeking assurances by interviewing pupils that they felt safe and secure and that their needs were being met in the broadest sense; not just in education, but in Health Services as well.

Q. At 5.8, you come back to point that before the 1995 Act, the HM Inspector of Schools inspection was very much concerned to educational matters?

A. Yes, yes.

Q. But that changed?

A. But that changed. Certainly as I think I've indicated, there was staff training undertaken for existing inspectors. I should say that the majority of inspectors would have been appointed after a career of at least 10 years in teaching. I think --

LADY SMITH: Professor Levitt, it's one thing to say that the key thrust surrounding an inspection was to seek an assurance that the young people felt safe and that children would actually be talked to during these inspections, but did you see any indication of inspectors being trained in how to talk to children, how to elicit information from children?

A. Other than inspecting a lesson being given. There is evidence that the existing complement were sent on training courses and new inspectors were appointed who had undertaken some sort of course in educational

psychology and educational welfare. So what one can see is that probably the majority of inspectors had no training prior to -- other than being teachers in the conventional sense. They would have -- it would be expected that they could not undertake the welfare inspection role that was being developed unless they had. That's as far as I got in terms of the information.

LADY SMITH: Okay.

A. I tried very hard to locate what you just asked.

LADY SMITH: You'll see what I'm getting at?

A. Yes, yes. It's not -- I couldn't find a document which said: right, this is precisely what you have to learn.

Or: this is the training programme.

I was looking for a training programme, but I was dealing with retained files at this stage, rather than the online material for the next report, and it really is a question of what has been retained.

LADY SMITH: Thank you.

MR MACAULAY: I think we saw that there was a proposal that there would be training, but I think your position is that was the case, but you haven't seen anything?

A. I haven't seen a training programme for existing staff, nor have I seen a pro forma which says that new Inspectorate must have undertaken some sort of child

protection training programme.

Q. Did you say a moment ago that the inspectors and the HMI would have been teachers?

A. Yes. The usual -- going back over a century, you are unlikely to be appointed to an Inspectorial role unless you had 10 years' experience in the classroom, which is what you would expect.

Q. So then if you go to the final point, at 5.11. What you say is this:

"At the end of the period under review, the HM Inspectorate of Education had seen their statutory powers of inspection extension and a new non-governmental public board, the Care Commission, assumed the registration and inspection of residential establishments, including secure accommodation. By contrast, the SWSI inspectorial functions were left open for further discussion as one part of an integrated framework for Children's Services."

A. That's correct, yes. That's clearly an indication that SWSI, in its current form, were, in some form, going to be altered, which the next section deals with.

Q. As we see shortly, that's what happened.

A. Yes, yes.

Q. Can I move on to the final report that covers the period 2005 to 2014, and just to repeat the reference. That's

SGV90807.

Again, Professor, so far as pagination is concerned, I'll be looking at the page numbers at the bottom right.

So far as your methodology and access to records were concerned, there is a change here, isn't there, to your previous reports?

A. Yes. This is primarily online. I was supplied with, as I say, a Government laptop, with secure access to all the necessary files that would be required for this particular report. I'm extremely grateful for the amount of assistance I was given, because trying to navigate Government files is a bit of a nightmare and they were very helpful in being able to locate where particular files might be or rather particularly email files might be.

Q. In particular, as you tell us on page 19, under the heading "Methodology" you had access to the eRDM Government system?

A. That's right, yes. That's their online.

Q. That's their online?

A. Yes. It appeared to have changed in around about 2005 where everything went online.

Q. You go on to tell us what that involved. In any event, is it the case that reports by the Care Commission or the Care Inspectorate were published?

A. Published online.
Q. Online.
A. That created a few problems as some of the reports were no longer available online. One had to use devious means to find them online or secure them from the Care Inspectorate, HMI Inspectorate of Education and so on.
Q. Now then, can we then look to the body of the report? The first section that you have -- I think mirrors your previous report -- is in relation to the legislative and administrative framework of inspection services in the period that you are looking at, 2005 and 2014.

Here, essentially as before, you set out the legislative framework.
A. Yes.
Q. Do you begin by telling us that in the summer of 2004 the Scottish Ministers commissioned a review into social work, really on essentially a root and branch review?
A. Yes. I think reflecting the last paragraph of the previous report, decisions had to be taken on the future of the Social Work Services Inspectorate in relation to the review of the quality of Local Authority Social Services and the quality of provision for looked-after children generally, and this was, if you like, the initial initiative, if you like, in terms of: how do we reconfigure the inspection services for looked-after

children?

Q. Do you know who was pushing this initiative?

You related to the Scottish Ministers, but was there a particular body or individuals who were pushing for these changes?

A. I think it was coming from the First Minister.

Q. And the First Minister of the day, remind me: who was it?

A. Mr McConnell.

Q. And the review was to -- into social work had this overall aim to:

"Take a fundamental look at all aspects of social work in order to strengthen its contribution to the delivery of integrated services."

A. Yes, yes. So it was a root and branch review, which led to, if you like, a reconfiguration of the system of inspection of education, of local Social Services, and particularly services for looked-after children.

Q. As you go on to say there, the system of inspection, at the time headed by the SWSI, lacked "focus on performance improvement."

You go on to remind us, as you've already said, that at that date there had been no routine inspection of Social Work Services in Scotland?

A. Yes, that's a phrase. "Focus on performance

improvement" is a polite way of saying: yes, we were wrong. We ought to have begun reviewing quality of services much earlier.

Q. It seems an obvious area to review, namely, those who are providing the services. Whereas the focus seems to have been on whether the services were being carried out in schools, for example.

A. I think there was an acceptance that phrase "an indication there is an acceptance" the actual inspections were quite limited in scope. And, yes, the SWSI could, under the 1968 Act, undertake inspections, but it was a more laborious process to initiate.

Q. Are you talking about inspections of the services?

A. Inspections of the service, of the quality of the services. There was no routine system for inspecting the quality of services at this time.

Q. Did the SWSI have the manpower to do a more thorough type of inspection?

A. My judgement is they didn't have the manpower. The number of inspectors was such that they were fully stretched in covering certainly looked-after children. One must remember that reviews of deaths in care, or the number of deaths per annum might not have been large, 10 or 12; right? The amount of paperwork involved in reviewing a death in care; right? And in secure

accommodation certainly would appear to consume all the time of the dedicated Inspector. And given that there was an Assistant Chief Social Work Inspector for that area, plus I think four others, it didn't leave a lot of time to undertake any detailed review of the quality of services across the board.

LADY SMITH: I suppose particularly reviewing a death in care would be something where it's very difficult to predict in advance how many hours and days will need to be devoted to it?

A. Yes. Clearly, there were some deaths that -- particularly through natural causes, once you got the paperwork in from the local Social Services and from the Health Services, fine. But there were other cases, particularly dealing with substance misuse, where there were suicides or other deaths, particularly if it involved a fatal accident inquiry would go on for some time.

MR MACAULAY: Do you go on to say that amongst its objectives the review aimed to:

"Develop a strong quality improvement framework and culture, supported by robust inspection."

And within that "strengthen leadership and management, giving clear direction to the service."

A. That's right. And I think I have underlined the issue

of leadership and management because that appears quite frequently. When the inspection reports were eventually completed, and the quality grading for leadership and management was not particularly high.

Q. There I think you're quoting from the 21st Century Social Work Review, Changing Lives 2006?

A. That's right, yes.

Q. So how then was this approached? What were the priorities in putting this into action?

A. The initial, I think, thrust was to look at: we need to review the quality of local Social Services and develop a scheme which could effectively grade the quality of local services and in a number of categories, and pinpoint within that quality assessment where there might be weaknesses and where changes might be required to improve the overall quality to at least adequate, rather than fair, shall we say?

Q. You mention, in 1.1.2, the need to establish "performance improvement framework"?

A. Yes, yes. That was following the school improvement framework, and then being developed by the integrated children services plan, which I talk about later. Following that, the key, therefore, was to somehow or other reform Social Work Inspectorate in a way which it would then take forward the substantial task of visiting

and reviewing the work of local Social Services, of which there were 32 in Scotland.

Q. At 1.1.3, do you perhaps tell us what happened then with that aim?

A. In April 2005, the Social Work Inspectorate was dissolved and Social Work Inspection Agency, headed by a Chief Social Work Inspector, was appointed.

The Minister of Education and young people approved its framework document, indicating although it was independent and impartial, it would remain directly accountable to Scottish Ministers for the standards of work. So that the professional judgement would certainly be the core of undertaking any quality assessment within the general context of ministerial desires to improve the quality of local provision.

I think it's important to stress that the issue was that it would be professionals, professional social workers, undertaking the quality assessment, within the broad framework of ministerial desire to improve the quality of services.

Q. You indicated -- as I think we have already looked at -- that at the time of the establishment, the SWI powers of inspection rested in section 6 of the Social Work Scotland Act.

A. Yes, yes. That did enable the Inspectorate to conduct

any inspections it wanted, but of course that was seen to be a rather cumbersome way of doing it. And in reality, I think Ministers accepted that there would have to be a change of legislation.

Q. As we look on, do we see that?

A. That's right, yes.

Q. But the framework document, you mention at 1.1.5, was designed to set out the key objectives that SWIA had to pursue?

A. Yes, it involved reviewing all local Social Services Departments throughout Scotland on a rolling programme, publishing the reports, indicating whether there were weakness, and I think later on I say a scale was developed to indicate weaknesses. And that all documents would be available for inspection.

And I think I've mentioned the restrictions previously on the documents in the third report, restrictions on the documents that an Inspector could review. The aim here was any document relating to the quality of local Social Services would be available for review.

Q. I think if we look at documents like medical records --

A. Medical records, yes, all right, there would have to be a special approach dealing with medical records, but that might involve a Department of Health Medical

Officer being involved.

Q. This notion of the SWIA being expected to promote public accountability by publishing regular reports; can you just explain that to me?

A. I think if you go on and look at an actual report and see at the end of it that there are quality assessments going from the very good down to inadequate, then that's an indication in terms of the agency indicating to the public generally that the quality of services demanded some improvement. And the detail of the reports themselves would indicate where the weaknesses lay.

Q. And these defects would be in the public domain?

A. In the public domain, on the internet, available to anybody to review. Unlike in previous cases, where very early on they were completely private to Ministers and then, subsequently, they were published, but distributed only to schools themselves, perhaps, and parents' bodies, and that was it really. It might be deposited in the local library. So this is completely open.

Q. This is quite a bold move, because it might be said it could leave politicians, in particular, open to criticism if the reports of services in their areas were being criticised.

A. Yes. And I think we see that later on, that it caused a number of headaches, shall we say, where reports

indicated there were severe weaknesses in the quality of services being provided.

Q. I think you tell us -- and I may have mentioned this already -- that the establishment of the SWIA was in the capacity as an executive agency of the Scottish Executive?

A. That's right, yes. Obviously, as the agency officials were members of the Scottish Government, Scottish Executive and then Scottish Government, they were still civil servants in a direct sense. And so there had to be some formula for relating their work to the ongoing work of the relevant department, and some connection between the work that they were doing and reporting through officials to Ministers as to the work they were doing. And any issues that emerged.

Q. Then, at 1.1.9, on page 27, do you tell us that following the establishment of the SWIA, the Scottish Ministers approved a three-year programme to inspect Social Work Services in each of the 32 Scottish Local Authorities?

A. That's correct, yes. And they began with a pilot, with pilot inspections in three Local Authorities to refine its approach, really making sure that they had the right sort of questions and they were reviewing the right kind of documents to gain the information to make their

quality assessment.

Q. Do you tell us in that paragraph that the model that was to be piloted was structured around six key questions?

A. That's right, with a six-point scale, from excellent to unsatisfactory.

Q. And I think within 10 areas for evaluation?

A. Yes, yes. Yes, yes. In effect, those six areas remained throughout this particular period in some shape or form.

Q. Next paragraph, you say that the primary function of the SWIA was:

"Deliver rigorous inspections" that would "drive up standards and improve the quality of services across Scotland".

A. Yes.

Q. That was the prime function?

A. Its prime function was to ensure public accountability and public support for the services that were being provided, given that certainly by 2000-plus a substantial number of services concerning social care generally, and for looked-after children, had expanded over the last 30/40 years.

LADY SMITH: I think you had observed regarding that period and around then, late 1990s, 2000, it was becoming harder and harder for the inspection, SWSI, for their

advisory role actually to be fulfilled, because of the lack of manpower. They couldn't do everything. They were getting involved in inspections for so much of their working life.

A. That's right. So this involved, really, effectively -- I think I make it clear that the policy input, the input of policy, into policy, by the Inspectorate was diminished considerably from around 50 per cent to something like 10 per cent. So they were freed up, the existing staff were freed up to conduct these inspections.

LADY SMITH: Yes.

A. That has implications --

LADY SMITH: There is a downside to that --

A. There is a downside to that, yes.

LADY SMITH: -- because it means that people who go to the coalface and really understand what is happening on the ground are having less and less influence on policy formulation.

A. The issue is that the quality of the officials in the appropriate looked-after children section, division, to be able to appreciate and understand the changes that were occurring, if they weren't having that 50 per cent input, 10 per cent input.

LADY SMITH: Thank you.

MR MACAULAY: You mentioned the pilot inspections to test the nature of the inspections and, at 1.3.13, you do tell us that there were pilot inspections in two areas, I think.

A. Yes, yes.

Q. To test the methodology of the proposed programme with a set of draft quality indicators based upon the framework; is that correct?

A. That's right, yes.

Q. What was the outcome of these inspections?

A. I think one needs to understand that they were asking questions such as how effective the help is that children and young people get when they need it; how actively children and young people in the families are involved in decision-making, and this relates to Children's Services, particularly; how the linked professional agencies worked together to protect children and, significantly, how effective individual and collective leadership is in terms of maintaining the quality of services.

But there was clearly an issue concerning the information supplied by health professionals.

Q. Yes.

A. And the inspectors would have liked to have had information on the effectiveness of Mental Health

Services and the monitoring undertaken by health visitors and school nurses.

Q. I think the law was changed to allow that to happen.

A. The law was changed to allow that, yes, subsequently.

As I say here, it was confirmed by the First Minister that they would introduce tough new inspection regimes for the Child Protection Services.

Q. Perhaps just to get it in the transcript, the full quotation is -- and this was in September 2005, an announcement:

"We will push forward our plans to introduce a tough new inspection system for our Child Protection Services. We will strengthen inspection powers to make sure Inspectorates can work together effectively in the interests of securing improved protection for children."

A. That's right, yes.

Q. Strong words.

A. Well, that's an indication that the officials concerned with looked after children, and certainly the Social Work Inspection Agency and HM Education Inspectorate, knew that they were being supported in terms of what they were doing, very clearly.

Q. In the next paragraph, you draw attention to the 2006 Act, the Joint Inspection of Children's Services and Inspection of Social Work Services Scotland Act 2006,

and that was an important piece of legislation.

A. It was important on two fronts. Firstly, it indicated that HM Inspectorate of Education would lead in terms of the inspection of Children's Services, in collaboration with other bodies, including the Social Work Inspection Agency, the Care Commission, NHS Quality Improvement Services, HM Inspector of Constabulary. And, at the same time, the Act also enabled the inspection team to share confidential information without explicit consent of the patient.

Importantly, I think, it created social work inspectors, which had not been within the 1968 Act. The 1968 Act enabled the Secretary of State to appoint anybody, and this deliberately appointed social work inspectors.

Q. You are building up a professional cohort?

A. That's right, yes.

Q. You tell us at the end of paragraph 1.1.5 that the regulations came into force on 3 November 2006?

A. That's right, yes.

Q. And the Act and regulations thus placed the SWIA inspections of Local Authority and Social Work Departments on a statutory footing.

A. Correct, yes. As opposed to an implicit footing, if you like, under the 1968 Act.

Q. Now, if we look at 1.17, you are looking here at the HMIe.
A. Yes.
Q. And that had been created as an executive agency of the Scottish Ministers in 2001?
A. That's right. That effectively pre-dated the Social Work Inspection Agency and the same formula as to its working and its relationship with the Scottish Government -- Scottish Executive, First Minister, Scottish Government and Scottish Ministers -- was very much the same in terms of how it reported and its link to the administrative officials and Ministers.
Q. But it too operated independently and impartially whilst remaining directly accountable to Scottish Ministers for the standard of its work.
A. Again, it was seen to be the important thing is it was professionals undertaking the assessment.
Q. You say, in 1.1.19, that the HMIe was headed by an HM Senior Chief Inspector and he was accountable to the Ministers?
A. He was accountable for the work of the Inspectorate. And within that, importantly, a number of directorates, HMIe Directorates had been established. Directorate 1, as I say, he covered secure units, independent schools, care and welfare provision, child protection and pupil

welfare.

And outside of the five directorates was a Services for Children Unit and that unit was then responsible for working with other agencies, Government inspection agencies, and the Care Commission for a common approach to inspecting Children's Services.

So there was a very clear division of responsibility within the Inspectorate in this period.

Q. The head of the SEED -- and we may not have looked at this, but he assumed responsibility for the SWIA; is that right?

A. That's right, yes.

Q. And also for the HMIe?

A. That's correct, yes. It was within education, and I think in the previous report it seems to be in the Home Department or Health Department, but now it's very clearly within education.

I think I also want to bring out that the Services for Children Unit by 2007 had been allocated directly to one of the six HMIs for the function of inspection of Children's Services, ie Directorate 1. So within the inspection of education, there is one directorate which has responsibility for looked-after children in the wider sense.

Q. And that's a good thing?

A. If you look at it from a different point of view it's a good thing because you know somebody is responsible and you can then -- a minister can ask that particular senior Inspector for information in regard to that particular inspection result.

LADY SMITH: Just to be clear: how is that better than what was happening, say, around 2000, the late 1990s?

A. It's not clear whether the HMIe Directorate fully encompassed the issue of Children's Services.

By 2007, you had a named individual, and it's there in the published handbook, which I quote here somewhere, yes, it's in Civil Service -- but you can see it's there, that one person is named as responsible, at a senior level.

LADY SMITH: In that one unit of the --

A. That one directorate. I think it's a Chief Inspector.

LADY SMITH: Directorate Number 1.

A. Directorate Number 1. That person is responsible for the overview of Looked-after Children's Services within education, and that encompasses the -- clearly, the work of the inspection of local Children's Services across the board, including secure accommodation.

MR MACAULAY: And with responsibility comes accountability?

A. Accountable, yes. Accountable in Parliament.

And that's a change, that you actually have someone

who is responsible for the development of those services and its performance.

Q. You go on to say, on page 32, at 1.1.21, that in November 2005, the HMIe published a consultation paper, with the title:

"A common approach to inspecting services for children and young people."

A. Yes.

Q. Can you just tell me about that? What was this seeking to do?

A. It was seeking, basically, to ensure that there was some degree of confidence in, if you like, the questions or the approach that would be taken in inspections, and that the tests, if you like, were appropriate. And the tests are listed here 1 to 6. Those general areas formed the basis of the valuation of local Children's Services, from highly satisfactory to unsatisfactory.

Q. We'll come to that in a moment. But, just to look at this, these have been developed -- extended from the five quality indicators that had been used in the pilot scheme?

A. That's right, yes. Yes, yes.

Q. We can see:

"What key outcomes have we achieved? How well do we meet the needs of our stakeholders? How good is our

delivery of services for children and young people? How good is our management? How good is our leadership? What is our capacity for improvement?"

So these were the --

A. I think the key thing is that is an indication that quite serious thought and work was done on seeking to develop an appropriate approach to reviewing and evaluating Children's Services, and these were, if you like, the six areas that were developed as part of the pilot.

Q. As you say, you look at the quote. These would be at the core of the Joint Inspection Services for Children?

A. That's right, yes. Everyone would know it, know that those are the questions that would be asked before the Inspectorate arrived.

Q. So the service providers would know that?

A. Yes. Yes, yes.

Q. At 1.1.23, you draw attention to some other legislation and policy announcements; can you tell me about that?

A. The Education (Additional Support for Learning) (Scotland) Act 2004 created a duty for education authorities to make arrangements to identify those children and young people who have additional support needs and who, without that support, were unlikely to benefit from school.

That effectively meant that there should be a statutory co-ordinated support plan for each of those children and young people concerned. And that essentially sought to ensure integrated working across the various agencies, Health, Education, Social Services. Some of the issues we have seen in the previous report where the Inspectorate, certainly in secure accommodation, were going for; what kind of integrated plan have you? It's now part of the legislation.

Q. Right.

I think you tell us on the following page that in 2015 there were 16 additional support needs schools?

A. Yes, yes. That is the number that I could establish at the end of this period of review. I think there were slight variations throughout the period of review, but that's the number I've actually got for the end of the review period.

Q. These were residential schools?

A. Yes, residential schools. Some provided day education as well.

Q. As you tell us, and as we have looked at some of these, some of them also provided secure care?

A. Yes, Rossie, Good Shepherd, Kibble and (inaudible).

Q. Now, the second piece of legislation you thought was

significant is the School Education (Ministerial Powers and Independent Schools) (Scotland) Act 2004.

A. Yes.

Q. Can you just explain why this was an important piece of legislation?

A. Effectively, following an inspection of independent schools, the Scottish Ministers could direct action by the School Managers in the light of the requirements and recommendations made.

Therefore, the information required from the school was extended for its registration with the Registrar of Independent Schools, and this altered the 1980 Act in the sense that it now included pupil numbers, pupil age range, details of teachers, whether the school is to cater for children with special educational needs, details of the proposed curriculum, health and safety arrangements and copies of child protection policies.

There are other sort of subclauses to that. But, basically, what this did was it strengthened, if you like, the review power of the Registrar of Independent Schools before a new school could be registered.

Q. The Registrar of Independent Schools, I think the Registrar was also located within the schools division?

A. Yes, and had been since the late 1950s. I think in conventional terms they were the head of a branch within

a division. Now, the nomenclature changes over time, but in my language that is a middle-ranking official.

Q. You mention the Crerar Review, at 1.1.26, commissioned by the Scottish Executive in 2006, and the remit was to evaluate the system of regulation audit inspection and complaints handling of public services in Scotland.

Again, this was quite an important landmark, this review.

A. Yes, it was. Clearly, there were external issues concerning public funding and the need, perhaps, to direct the attention of any inspection agency to where there might be perceived weaknesses within Local Authority and other associated services, and so the phrase, the word "scrutiny" appears in the literature for the first time, which is an indication that there will be considerable scrutiny of all of the available information concerning local services for looked-after children and others.

Q. This review, I think one reads here, considered that the existing system of central Government control was overcomplex.

A. Yes, I know. I sort of put that in to sort of bring out sort of language of the period. But I think it's more important to understand its impact on the emerging inspection services, particularly for looked-after

children.

Q. And what was its impact, in your view?

A. Its impact, certainly from 2010 onwards, was to look particularly at where there was evidence of weaknesses in services and to engage more frequently with the services concerned to improve its quality.

So instead of the sort of overall inspection approach, this was a much more targeted approach. I think I do mention later on that the inspecting agencies would be reviewing a whole variety of indicators, in terms of where there might be weaknesses and, therefore, they would then target those -- that particular Local Authority or those particular local services. And I think some of the examples further on in the report indicates: yes, we know that there are issues here.

Q. Does the Crerar Review feed into, ultimately, the creation of the Commission?

A. Yes, yes. I think it was felt that there were too many inspection agencies, and if one is looking at public costs and also ensuring similarity of approach, that one should bring as many of these agencies together as possible.

So the Care Inspectorate were formed in 2011, April 2011, on the basis of the Care Commission, Social Work

Inspection Agency, and a number of education inspectors, as a single body.

It might appear complex, but I think the key thing is that the Care Inspectorate led from 2011, led the inspection of Looked-after Children's Services.

Q. Before that it was the HMIe?

A. Yes, the HMIe.

Q. The legislation for the Care Commission was the Public Services Reform (Scotland) Act 2010?

A. Yes.

Q. Which led into the Care Inspectorate.

Perhaps we can move on to 1.1.32, on page 36. Because here you say the approach of the HMIe mirrored that of the SWIA. It noted that:

"Scrutiny is a process of review that focuses on the effectiveness of strategic delivery of services."

So, again, the keyword is "scrutiny"?

A. Yes, and the issue there is, I think, in the next paragraph, the phrase "risk assessment", and that the reviewing documents, in terms of where there might be added risk or excess risk, or any risk at all to the provision of services for looked-after children.

And the detail is that they would look across a range of documents. And not just documents concerning the children themselves, but the number of staff

employed, the expenditure on a particular service as well, and so that would get a composite view of whether or not there was a risk.

Q. If you look at the final paragraph of this section, 1.1.34, do you explain the connection between the Care Inspectorate by this time and the Scottish Ministers and, in particular, that the Care Inspectorate was required to prepare a plan in consultation with the relevant Scottish Government policy interests and have that plan approved by Ministers?

A. Yes. It was virtually the same as for the Social Work Inspection Agency and the HM Inspector of Education. There would be a plan, except the difference was of course the Care Inspectorate was a non-government body and, therefore, an independent body, who reported to Scottish Parliament independently.

Q. Yes. I think it was a body corporate?

A. Yes.

Q. Very well. Then the review of this section, you are looking to page 38; can you perhaps just summarise that for me?

A. Clearly, there was significant transformation in the inspection services, certainly for looked-after children, and children in any form of residential accommodation.

It was not thought that the SWSI in terms of simply providing advice and guidance was relevant and that the establishment of an inspection agency, whose staff were primarily focused on conducting a rolling programme of inspection, would ensure public confidence in the quality of those services. And by assessing on the six-point scale where witnesses lay, that those services would be improved. And we'll see that later on.

Certainly, the Acts of Parliament, education, additional support for learning and the School Eduction (Ministerial Powers and Independent Schools) Act further enhanced the powers of inspection, and the power to obtain information in relation to the quality of services.

Q. You indicate that the Scottish Government accepted the care report?

A. Yes.

Q. And that the term "scrutiny" meant a targeted approach to assess --

A. Yes. Where, as I say, across a whole range of documents; not just in terms of the file on a child, but also on quality of staff that had been appointed, the number of staff, the total budget allocated to particular services were also to be looked at as part of the assessment of risk.

Q. As we saw, the SWIA didn't take over from the previous SWSI. I think SWSI was dissolved and SWIA stepped into its place?
A. That's right.
Q. But SWSI, one of its roles was advisory and the role of SWIA, essentially, was to be inspectorial.
A. That's right, yes.
Q. Did that have an impact then on the advisory?
A. I think one could stand back and say: if there is less professional advice going in to administrative officials one would question just how much information was -- Ministers were being told in terms of the issues at large.

And I think that would be a criticism I would have really, that once you divorce professional advice directly, what takes it place in terms of advice going to Ministers?
Q. I think you tell us here that a new Scottish Executive Education Department division Social Work Policy Services were intended to fill the gap?
A. Yes, yes.
Q. And did it, or did they?
A. I think we'll come to that later on in the report.
Q. Very well. Let's move on to section 2, where you look at the inspection of Local Authority Social Work and

Children's Services in this period.

You begin by telling us that following the decision by the Scottish Executive in 2004 to set up a multi-disciplinary Children's Services Inspection Team led by HMIe and the passing of the Act, the 2006 Act, together with the regulations and codes of practice provided the framework for the conduct of the inspections and enabled the services to access and share information.

A. Yes.

Q. And HMIe hosted the multi-agency team, with representatives from different organisations.

A. Yes. Let me explain that in undertaking the research for this particular section, one clearly had the published reports, even though I had to scramble for them. The published reports, if one looks at the end, gives an indication of the score, the rating for that, and it also gives an indication of the previous rating, so you have a timeline.

If you go to a report in 2015 and go back 10 years, you'll find a particular rating. Now, what I did was to -- where there was indication of weaknesses, where there were poor scores, I concentrated, if you like, my attention on those Local Authorities which had the weakest scores or looked at Children's Services which

had the weakest scores.

Q. Do you mean those were the ones that you selected to include in your report?

A. Yes. The majority of services that were being reviewed had average or above average and did not come to the attention of Ministers or officials. One concentrated on the reports which were relatively poor, which then fed into the administrative system and fed into Ministers. And so these case studies are, if you like, the poorly performing services at the point of inspection.

That's why I was so keen to get a complete list of all the inspection reports, so I could go through them to confirm in my own view: yes, absolutely, these are the ones which I think the Inquiry might be interested in.

Q. Are you saying that the snapshot that you've given us in your report doesn't fully represent or at all represent the overall picture across Scotland?

A. I think I do mention, right, that the majority -- and it does go to Ministers at various times, and I do reference documents which says to Ministers: yes, these Local Authorities, these Looked-after Children's Services are fine. But these are the ones which we are most concerned about.

Q. Yes.
A. And I think to understand the fact that in reality where you had a good performing authority or good performing services, it would be ticked off, if you like, by the administrative official and the Minister would never see it. I would have thought the Inquiry would be interested in where there were issues concerning those services which required administrative and ministerial actions.
Q. Certainly, when we look at your selection, there are some very concerning findings.
A. Yes. These are the ones that are brought out here.
So the majority of inspections were positive or at least did not require any action. And in that sense, the Care Commission, HMIe Education, and the Social Work Inspection Agency carried on and there was no necessity for any action from the Scottish Administration; does that make sense?
Q. Yes, thank you for that. I think you do make that point in the report.
A. Yes.
Q. The majority essentially get a clean bill of health.
A. Clean bill of health and, therefore, requiring no action.
Q. Just to identify who may have been involved in the

inspections, if you look at paragraph 2.1.1, first of all, you say that HMIe hosted the multi-agency team and with representatives from the SWIA, the Care Commission, His Majesty's Inspector of Constabulary and NHS QUIS.

A. Right.

Q. So a significant team?

A. A significant team, led by Directorate 1 in HMI Education, so it's important to bring that out. It's that directorate which are running and managing the collaborative exercises going on here.

LADY SMITH: The total wrap around is the provision of services for children?

A. That's right. That's what the directorate was set up to do.

MR MACAULAY: If we go towards the top of page 40, you say:

"As the intention of the 2006 Act [that is the Act that set out joint inspections] was to encourage and develop the collective responsibility of the local Child Protection Services, the inspections set out to evaluate the services at three levels."

And you set out what these levels are.

A. Yes. I'm certainly paraphrasing what's in the report, the strategic leadership and planning, systems and processes, and the experience of service users and impact on the individual child.

Q. You point out -- you may have mentioned this before -- that the inspectors were expected to read a sample of case records.

A. Yes, yes.

Q. And interview key staff and interview children.

A. Yes, yes.

Q. Now, you go on to talk about the inspection methodology at 2.1.3; can you just flesh that out for me?

A. Clearly, when you are engaged in such a large exercise -- and this was a substantially different exercise to something in the 1950s and 1960s -- you are moving on from two pages to a substantial document, and substantial review of documents, so you have to ensure that the agencies concerned are aware that you're about to approach them and you will be looking at a whole variety of documents, and you will be seeking to interview both providers and service users.

That would follow from -- from that would follow -- there would be a verbal briefing to the agencies, leaflets issued, and the processes that would be followed; that any individual case records would be anonymised, and that would form a further basis for more detailed investigation and review of cases.

And the agencies would be informed of the published framework of quality indicators, which were published on

net as well. It wasn't anything that was hidden from the public.

And they follow the key questions that we looked at before.

Q. You tell us, at 2.1.3, for example, that 12 weeks' notice in advance of the inspection would be provided?

A. Yes.

Q. And then, thereafter, there would be a verbal briefing with the service provider.

A. That's right, yes, yes.

Q. And the framework, the public framework of quality indicators, was said to answer the five key questions that you have set out there again?

A. Yes, yes.

Q. And moving on to the next paragraph, on page 41, and you have mentioned the indicators:

"At each inspection, the indicators were used to assist the inspectors to form a view of service effectiveness and assess whether they were excellent, very good, good, adequate, weak or unsatisfactory."

A. That's correct.

Q. So these were the indicators that would be set out in a table in the report.

A. A table in the report, at the end of the report, would be the indicators. And as I've said, if you go to 2015,

you can go back and they all report each evaluation according to these indicators. So you have a good idea whether that service remained strong or whether there were weaknesses at any particular point in time.

Q. What are the differences between, excellent, very good, good, adequate? We can perhaps understand weak.

A. Yes, it set out that looking at the material, I think the key issues surrounded reports and evaluations that were weak or unsatisfactory, and it was these that tended to result in official review and ministerial review. And if a weakness -- an evaluation -- indicate the service's weaknesses outweighed its strengths and that there may be some strength and the important weaknesses, either individual or collective, diminish the experiences of children and young people and the families in substantial ways. And that will mean there has to be, certainly, a plan put in place to improve the services provided.

Unsatisfactory, implied, as it says, immediate remedial action, which is a clear indication that there would be a pretty close follow-up to any report which said "unsatisfactory".

Q. At what level would you think that the Minister might be made aware of a problem or potential problem?

A. Looking at the indicators, if it indicated the impact on

service users was weak and certainly unsatisfactory, and that the management was weak and/or unsatisfactory, then officials would inform the Minister. And I think we go through that in some of the reports.

To me, the key surrounds the issue of the management of services, and that seemed to be the key litmus test. If the management of the services are weak, then clearly there are particular issues in terms of the quality of care that's being provided.

Q. Let's assume then we have a situation where there are concerns identified, whether in the unsatisfactory or weak context; what would happen next?

A. I think we have examples later on, but the issue really would be that the report would be received by the officials within the Looked-after Children's Division and Looked-after Children's Branch, who had responsibility for liaising with HMIe and, after discussion among themselves, they would probably -- an example case here -- issue the Minister with a minute indicating their concerns and the actions that should be taken at a political level, which might be meeting the relevant agencies, meeting the chair of the local Children's Services Group to ensure that remedial action was taken.

Q. As we've seen previously, would the provider be provided

with an action plan?

A. The issue would be: we must see your action plan.

Q. Putting that round the other way, the provider would be asked to provide an action plan?

A. Yes, an action plan to meet the deficiencies that the report had indicated.

Q. Again, we have seen this in other instances. Would there then be a follow-up?

A. Yes, usually within 12 months, sometimes within six months, and that might lead to a further follow-up if in fact the requirements had not been met.

Q. You also talk, at 2.1.9, about the SWIA's performance improvement model; can you just discuss --

A. Could I go back to 2.1.7?

Q. Yes, please.

A. HMIe were reluctant to quantify the results in terms of a score, but certainly scores were produced. As I say, I tended to go by the score. If you actually look at the poor reports mentioned here, they scored badly when you actually quantified them. So there is a reluctance to do it, but they did. I think I need to bring that out.

Q. Why was there a reluctance, if you are being open about it?

A. Methodologically there are some issues when you are

trying to quantify qualitative results, because they're not quantitative results, they're qualitative results. So if you are saying you've a six-point scale, and then you give each indicator a six-point scale, and then you end up saying the actual score for this particular group of services or Local Authority is below a certain point, then overall it's weak or unsatisfactory, or worse, unsatisfactory. And although they disliked it, these scores were circulated round officials and, I assume, Ministers as well.

Q. I suppose that a score provides a clearer message in a way?

A. Underlines the importance to the Minister that action must be taken.

Q. It's a simpler message in a way, too.

A. Easier to quantify, even though you shouldn't really quantify qualitative results.

LADY SMITH: What about the risk of subjectivity having an impact, subjectivity in terms of choice of number varying from one group of inspectors to another group of inspectors, whereas they might all have agreed: well, that was weak?

A. That is an issue which I think comes out in some of the reports; that there are clearly borderlines between weak and adequate. I think there are some cases where

a score of "adequate" was given where it perhaps should, in subsequent reviews, have been "weak" and therefore required action.

Q. We're looking at Ministers and officials as well, and we see this, I think, from the examples; would a draft of the report make its way to the officials before publication?

A. It shouldn't have. A draft report should be sent back to the agency concerned for discussion, but I think from the information I looked at, they weren't necessarily given a paper draft, but officials would be informed that this particular agency or set of agencies was scoring not so well.

Q. So there would be a degree of forewarning?

A. A degree of forewarning, yes. The agencies were meant to be independent. Particularly, the Care Commission was meant to be completely independent and the Care Inspectorate was meant to be completely independent.

LADY SMITH: How would the forewarning be conveyed if they weren't getting the document?

A. Verbally.

MR MACAULAY: You then go on to look at the SWIA's performance improvement model, at 2.9, that formed the basis of its services inspection.

A. Yes.

Q. As you indicate, its primary purpose was to provide a critical appraisal of the services to enable Local Authorities and the public to assess whether it was achieving what it set out to do, delivering value for money and making life better for its citizens.

Do you set out 10 areas that the inspectors would evaluate?

A. That's right, yes.

Q. This is looking at what the SWIA would be doing.

A. That's right, yes, yes. Across all Local Authorities and Social Services, so that would include mental health, the elderly, substance misusers generally, adult services, as well as children. So one has to realise that they've two separate sets of inspections going on from this particular -- from 2006 onwards.

One particular looking interagency working for Children's Services, and one looking at Local Authority Social Services in total, one part of which would be Children's Services.

Q. Yes. You set out the 10 areas for evaluation, including, at the end, the capacity for improvement.

A. That's right.

Q. We can read the rest for ourselves. You say at 2.10:

"At each inspection the Chief Social Work Inspector recorded later that the inspectors had ..."

You go on to say what they would have done, read case files, conducted surveys and interviews, and so on and so forth. So there would be a record made of exactly what had been done.

A. Oh, yes, yes. The actual file indicates -- and I've seen paper copies of the files that indicate: yes, this group of individuals; this group of service users have been interviewed; this group of parents has been interviewed; this children's home has been reviewed; this logbook of incidents concerning a child has been reviewed.

I think it's quite important to establish the depth at which these particular inspection reviews were undertaken.

Q. We can see this is quite a significant shift from what had been happening before 2005?

A. Precisely, yes.

LADY SMITH: Is that a convenient stopping place?

MR MACAULAY: Yes.

LADY SMITH: Very well. We'll take the morning break just now, Professor Levitt, if that would work for you, and we'll sit again in about a quarter of an hour.

(11.30 am)

(A short break)

(11.45 am)

LADY SMITH: Are you ready for us to carry on, Professor Levitt?

A. Yes.

LADY SMITH: Thank you. Mr MacAulay, when you're ready.

MR MACAULAY: Before the break, I was looking at the SWIA approach to inspections, and we had come to page 43 of the report. I think we see, at 2.1.11, that the inspection teams included full-time and sessional inspectors employed by SWIA, a person seconded from Audit Scotland, service users, care inspectors, as well as associate inspectors and senior managers from also councils in Scotland to provide an element of peer review.

A. That's correct.

Q. Again, a significantly large team.

A. Exceptionally large team, you might argue, historically, in relation to what you've seen in the previous report, where there were 100 lay observers for the various social work and education inspections.

Q. Do you envisage that the individuals that make up the team would all attend the provider at the same time or would this be spread over a period of time?

A. It would be spread over a number of days, and I've certainly looked at a substantial number of box files for one inspection. Box files like that

(indicating), and you can clearly see that individuals are being allocated to specific tasks across a number of days. They're headed, each group headed by a Social Work Inspector and then the report from the deliberations being put together.

Q. It's interesting to see that this approach did involve an element of peer review.

A. Yes.

Q. And I think that is new, isn't it?

A. It is deliberately new, yes, that you are actually getting service users involved within the scheme of assessment leading to, again, another six-point scale.

Q. You go on to say that the SWIA followed the HMIe in adoption of the six-point scale.

A. Yes.

Q. And, again, the indicators were the same, excellent to unsatisfactory.

A. That's right, yes. And the same quantification as you have seen with the Education Inspectorate was developed.

Q. Yes.

LADY SMITH: When you were referring to peer review; that's what you mention at the end of 2.1.11, is it, senior managers from other councils?

A. Yes, as peer review and other managers, associate inspectors, and associate inspectors might well have had

social work or associated background.
LADY SMITH: Thank you.
MR MACAULAY: As you explain at 2.15, that after the publication of each inspection report, the Local Authority was expected to complete an action plan.
A. That's correct. If there were weaknesses uncovered.
Q. Again, a follow-up inspection usually occurred about 12 months afterwards?
A. Yes. That's correct, yes.
Q. Now, you indicate, at 2.1.6, that the first HMIe-led inspection programme was completed in 2009 and had provided an overview of the existing strengths within the area's Child Protection Committee and the areas for improvement, so there was a three-year, approximately, period?
A. Yes.
Q. Did that mean that this programme had covered all 32 Local Authorities?
A. I think it had, yes. Without referring to my notes, I think all HMI -- Child Protection Services had been covered in that particular period, yes.
Q. Then the second programme was to begin in 2009 and go through to 2012.
A. That's right, yes.
Q. I think you do indicate that there may have been some

difference in approach; what differences in approach did you discover?

A. This relates to the scrutiny approach, if you like, where you're looking at the issues of risk assessment and you're trying to establish from past reviews, past inspection reports, as well as further information coming in from a variety of sources, whether or not you should be prioritising one service, as opposed to other services among the 32 in Scotland.

And that's what occurs. If you look at it on the ground, if you actually put all the reports together, you can see them emerging: yes, we need to look at this particular set of services, as opposed to that Local Authority Services.

Q. I think you set out there the indicators that were employed in the inspection programme, which were taken from the Scottish Government's National Performance Framework?

A. Yes. That's right, yes.

Q. That is the six?

A. Yes.

Q. Again, the same levels were used to rate each of these?

A. The same six-point scale was being used and, additionally here, and this is where the quantification comes in, a positive report required evaluations of

satisfactory or above across the first four indicators. So, in fact, they are actually beginning to quantify -- the system is beginning to quantify where in fact additional action might be required and additional visits might be required.

Q. This particular programme was initially led by HMIe.

A. Yes.

Q. With support from SWIA and the Care Commission. But, as time went on, it was the Care Inspectorate that led?

A. That's right, yes. From April 2011, I think it was, yes.

Q. Of course, SWIA dropped out of the picture completely.

A. Yes, yes, yes.

LADY SMITH: Do I take it from what you said earlier, about a positive report requiring evaluations of satisfactory or above across four of the indicators, that by then the indicators were weighted? If that's the right way to describe it. Some indicators were regarded as being more important than others.

A. Yes, they were quantifying the six-point scale. So you have a qualitative set of indicators being quantified and then a positive report coming from that or not -- or a negative report coming from that, according to the scores then developed.

LADY SMITH: You have the six points, and you said it was

the first four indicators that were feeding into --
A. Sorry, the indicators, whether it was "excellent" down to "unsatisfactory".
LADY SMITH: Sorry.
A. It's that quantification which is crucial to -- and particularly when you look at 2.1.18:
"Care Inspectorate produced an aggregate report of an inspection with Aberdeen City, Argyll & Bute, Dumfries and Galloway, and Stirling held at least one negative quality indicator."
LADY SMITH: Thank you.
MR MACAULAY: Just on that point, when you talk about an aggregate report, and you have mentioned these Local Authorities; what does that mean?
A. They simply produced a table of all the reports that they had done and put them together, and these authorities were at the bottom end.
Q. I think you tell us on the following paragraph that the methodology for the joint inspection of Children's Services conducted by the CI follow the approach adopted in the previous cycle of 2006 to 2009?
A. Yes.
Q. But you do go on to make some further comments on that?
A. They were particularly interested on records of vulnerable children, and this is where the scrutiny and

the focus of scrutiny lay. Children would be subject to child protection measures, looked-after children, including children in respite placements, unborn children whose family circumstances or history makes them particularly vulnerable, and young people leaving care. So, again, it's the targeted scrutiny issue that is emerging there.

Q. In the next paragraph, you go back to the SWIA's initial Performance Inspection Programme?

A. Yes.

Q. As we have seen, it was completed in 2009 and the new approach was introduced in part developed from the Crerar Report. This, you say:

"The primary purpose was of a new proportionate risk based approach to the scrutiny of Local Authority Services so as to provide independent assurance they were well managed, safe and fit for purpose."

LADY SMITH: That was developed partly from the Crerar Report that was Lorne Crerar's report from 2007 I think.

MR MACAULAY: Towards the bottom, you make mention there of the role of an SWI Link Inspector; can you tell me about that role?

A. The Link Inspector was replicating, basically, what had occurred among education previously, that an Inspector would be delegated to discuss with a school and, in this

case, with the Local Authority the implications of the report and what was required, and be available at the end of a telephone, if necessary, by personal contact, as to whether or not the response that was being indicated was -- would likely be acceptable. Any queries relating to the report would go to the Link Inspector and the Link Inspector would then advise them as to the range of improvements that would be required.

Q. As we have seen, the new programme of inspections was carried out, continued by the Care Inspectorate after April 2011.

A. Yes.

Q. Do we see towards the bottom of page, paragraph 2.1.21, that there was a programme -- was this another programme that ran from 2013 to 2017?

A. Yes, yes.

Q. So is this Programme Number 3?

A. This is Programme Number 3, if you like, yes, yes. Again, refining the issue of risk assessment. And it was published, so it's freely available. And it indicates that where there were concerns -- Orkney, East Lothian, Dumfries and Galloway were classed as weak whilst under the indicator assessing responding to risks. Stirling, Clackmannanshire were classed as weak, and Dumfries and Galloway were classed as

unsatisfactory.

Q. We are about to look at Dumfries and Galloway at an earlier stage?

A. Yes. So this was the follow-up, if you like.

Q. Then you tell us what happens next in your report. That the remainder of this section covers a number of case studies to illustrate the scheme of inspection of Local Authority Social Work departments and the services to protect children and young people in greater detail.

A. Yes.

Q. The principal aim of the studies is to account and review the response of Scottish Government Officials and Ministers to the issues of concern raised; that is what you are looking at, in essence?

A. Yes.

Q. As we discussed earlier, you have selected a snapshot that might be of interest --

A. The majority of the reports raised no issues and, therefore, it wasn't an issue of policy in practice having to be developed or action being taken.

So these are examples of where there were issues of concern being raised as a result of the inspections.

Q. I think you cover a period beginning with Dumfries and Galloway from 2005 through to, again, Dumfries and Galloway 2015?

A. That's right, yes, yes.
Q. Although there are seven case examples, two relate to Dumfries and Galloway, so we're looking at six Local Authorities?
A. That's right, yes, yes.
Q. If we then look at page 48, the inspection of Social Work Services in Dumfries and Galloway was conducted between January and April 2006; do I take it just from that, that tells us that there would be a number of different visits at a number of different times?
A. It's not clear from the published report the dates at which they conducted the inspection, and I wasn't able to trace the big boxes which contain the detail. But my assumption is that at periodic intervals between January and April inspectors visited Dumfries and Galloway in the format that I've already described.
Q. Would they be looking at different aspects of the services at different times?
A. Yes. Clearly, if you are looking at Social Services, as a whole, you are looking at looked-after children, the elderly, Mental Health Services, Adult Services.
Q. And this, you tell us, was the first full SWIA inspection since its inception?
A. Yes. That's right, yes.
Q. And part of the inspection process included the use of

questionnaires to service users and staff, submission of council documents relating to the provision of services, and also the inspection reports from other regulatory bodies, including the Care Commission and the HMIe. That's what I think we touched upon yesterday, because here we have an example of the SWIA having regard to reports by other Inspectorates.

A. It was obliged to have -- to review the reports conducted by the Care Commission and Education on related services.

Q. You introduce us to the findings of the report in the next paragraph and can you perhaps just summarise what --

A. The published report -- which again is actually available on the web, I can report -- indicates that the 10 areas evaluated, four were deemed to be adequate, five were weak and one strategic leadership was unsatisfactory. So the composite score, if you like, which wasn't meant to be a composite score, but the composite score was not good.

Q. I think you told us earlier that unsatisfactory in particular --

A. Yes, immediate action.

Q. -- needs urgent action.

A. Yes, urgent action.

Q. You mentioned the report is available on the web, and indeed it is. As is the case with these reports, they're very long.
A. Yes.
Q. And I think that particular report is 89 pages long.
A. Yes. Generally, they tended to be of that length. One can't say they were skimping in terms of the detail of the report.
LADY SMITH: I noticed that it wasn't published until September 2006, although you think you ascertained that the inspections actually took place between January and April that year.
A. You have a large body of inspectors. They have to meet and agree between themselves as to the six indicators. They then have to send the draft report back to Dumfries and Galloway, the council concerned, for their observations, and any factual inaccuracies, before it can be published.
LADY SMITH: Which all takes time.
A. It all takes, time, yes. It's five months of deliberation.
LADY SMITH: Meanwhile, if an action plan is needed, it's not formulated.
A. Yes, that's right, yes. They have an indication of an action plan needing to be formulated, but not until

it's actually published. So there is a time lag between the initial report, if you like, and an action plan.

MR MACAULAY: I understand what is meant in the sentence that beginnings in 2.2.2:

"However, within the services for looked-after children, the SWIA noted the council's policy of externalising residential services had resulted in a reduction of direct provision ..."

Could I just understand what that means?

A. It means they didn't have their own children's homes and they were sending children -- I think in this case, if one looks at the text more clearly, they were sending the children outside the Regional Council, outside the District Council.

Q. They did have, I think, two children's homes because these are mentioned.

A. Yes.

Q. But one was described as "like an office block" and "a building not equipped for residential childcare", so that's highly critical of the home.

A. Yes, it is.

Q. Were the inspectors told that they could only meet the needs by sending children and young people outwith the area?

A. Yes, outside Dumfries and Galloway.

Q. There was also criticism levelled at the low level of educational attainment of children leaving care and the level of aftercare of support to which they were entitled.

A. Yes, yes.

So this was an extremely critical report, the first report to be critical.

Q. This is not the dark ages. This is 2006 that we're looking at.

A. Yes.

Q. The report also commented that the Chief Social Work Officer was the sole member of staff within the Social Work Services Senior Team who was qualified as a social worker.

A. That's correct, yes.

Q. Does that surprise you?

A. For 2006, it does surprise me, yes, that there was only one professionally qualified member of staff among the senior team.

Q. I think in the next paragraph you do indicate that the Scottish -- that officials became aware of the report; is that correct?

A. That's correct, yes, yes.

Q. Do we know how that happened? I said "report", I meant the findings of the inspection.

A. The draft report was issued to the Education Department and it's as to the social work policies:

"Social Work Services Policy Division to review the powers of the Scottish Executive to intervene ..."

Where there was evidence that the Local Authority had failed in the delivery of their duties. And the consequent discussion surrounding at what level the intervention should be.

Q. Do we see that Dumfries and Galloway accepted in full the recommendations in the report? That's on the next page.

A. Yes, yes.

Q. Was this the pattern, as we go through these examples, that once the findings had been communicated the Local Authority accept --

A. Generally. But, in some cases, after the intervention of the Minister, and I think we've some cases later on where the Minister meets the Local Authority concerned and presses the points being raised by the officials and by the inspection report.

Q. Just on the issue of ministerial intervention, if you look at page 31, perhaps the previous page, 50, 2.2.6, the Minister obviously sought information about the Scottish Executive's powers of intervention here.

A. Yes.

Q. And what was the result there?
A. The advice was that the Local Government (Scotland) Act 1973, Local Government (Scotland) Act 2002, there were powers for Scottish Ministers to issue directions under the 1968 Act, but the issue was, really: what would you say, basically, when you are issuing directions? Would it be clear, unambiguous and a measurable direction in relation to concerns about the quality of services?

The Minister was then informed that the Minister's powers of intervention were not strong, were extremely limited, and it might be time consuming to ensure the remedial measures were undertaken.

Q. Did that mean they looked at alternative measures?
A. The alternative measure was to engage with the Local Authority concerned, discuss the issues at large and, if necessary, publish the report indicating Government concern.
Q. Do you set out, at 2.2.7, the steps that could be taken to help the Local Authority?
A. Yes. That in this particular case would provide advice and support, would seek to -- would seek to advise the introduction of external professional support and, in that way, meet the action points that the actual report indicated were necessary.
LADY SMITH: I noticed, also, Professor Levitt, you picked

up that one of the ideas at the end of 2.2.4, you capture it at top of page 49, is just to be more aggressive in driving improvement through public criticism.

A. Yes.

LADY SMITH: Which I suppose is all very well, but if you have an incapable council that's not going to actually help them to change their ways.

A. No, not necessarily.

LADY SMITH: Unless what you are really saying is that at the next local elections, maybe the local population will elect a different bunch of people that will run this council in a better way.

A. I think there are different levels at which a Local Authority is organised, and it might be that you are targeting the Social Services Directorate as opposed to the Principal Directorate, and if the Principal Directorate are saying to themselves: well, we have a problem lower down, we'll engage in management change. I think some of the later reports do indicate there are management changes afoot.

LADY SMITH: I suppose then any degree of change of councillors is going to have a limited impact if you don't have good management and good structures operating below that.

A. That is a possibility, yes.
LADY SMITH: We have also a very small council here.
A. A very small council. But the focus was not just on the councillors; it was on the senior management of the Council, and distinguishing between the senior management of the Council as a whole and the Social Services Directorate.
LADY SMITH: And one which, as I recall, also had problems in satisfactory provision of Foster Care Services.
A. Yes, yes, yes, yes.
LADY SMITH: Yes.
MR MACAULAY: Do we have here an example of the new regime looking under the carpet, so to speak, and finding a serious problem?
A. Yes, the first report basically indicating: yes, we have issues that the quality of services, as we probably expected, were not at the level we would have wanted and, therefore, the First Minister's direction in 2004 to move in this direction of assessing quality of local services was actually probably correct.
Q. Could you say it's a direction that the Scottish Government could have moved towards earlier?
A. I think I've sort of indicated that, yes, in 1992, when the Social Work Services Inspectorate was created, the assumption would have been, if you're looking at that in

the black: yes, there would be inspections of Local Authorities.

But that did not happen.

Q. In a sense, although the inspection here took a period of months, I think, one would suspect that the problems identified would not have developed overnight?

A. From the published report, it's difficult to establish what had happened previous to the report. All the inspection report does is report on the case as it is presented.

I think reading between the lines you can probably gather that they felt there were serious concerns with that council over a number of years.

Q. We have been looking at alternative approaches to any direct ministerial intervention, and you discuss that at 2.2.7.

I think we have mentioned external consultants, and also I think you mentioned the Local Authority could be offered the support and assistance of professional staff in other Local Authorities?

A. Yes, and I think that is what happened in this case.

Q. You mentioned before that one of the things the Minister could do would be to meet with senior management; indeed, do you tell us that that's what happened here?

A. The Minister did meet with Dumfries and Galloway senior

management -- that is not just the social work directorate -- to improve the quality of the Social Work Services.

Q. Clearly, the local constituents would be concerned about the findings in this report?

A. I assume so. But, of course, I wasn't looking --

Q. No.

A. -- for the records concerning with that.

Q. The reason I put it in that way is: if you look at page 32, towards the top, we have, after the report's publication, a statement by the First Minister in the Scottish Parliament.

A. That's right, a statement is made.

Q. And what he says is:

"We take report very seriously. The Minister for Education and Young People met representatives of Dumfries and Galloway Council on 28 August and wrote to its Convener and Chief Executive ... he reinforced his concerns at the findings and welcomed the Council's clear commitment to take the action necessary to bring about improvement. The Inspection Agency will keep Ministers informed of the Council's progress, and conduct a follow-up inspection in a year's time."

LADY SMITH: That is the top of page 51 in Professor Levitt's numbering and 52 in our numbering.

MR MACAULAY: And I think the First Minister goes on to explain what steps were being put in place to assist.

A. Yes. I think it's important to understand the format of the response. Clearly some very serious concerns about Dumfries and Galloway which led to the Minister meeting the Local Authority, not just officials and that being reinforced in the Scottish Parliament. And an agreement reached, obviously, reasonably quickly as to the remedial action required.

Q. If we read on at 2.2.9, that the Council submitted an agreed action plan --

A. Yes.

Q. -- in December 2006.

A. That's correct, yes.

Q. We then learn about the follow-through inspection in 2008; what did that discover?

A. It's important to recognise that there was a follow-through inspection. It wasn't: we'll come back in ten years' time or five years' time. They wanted to review the implementation of the action plan.

It obviously gave them 12 months to undertake that between draft plan -- between the draft report being available in the middle of 2006 to then. So they're being given time.

It noted that some of the recommendations to

approve/assess had not been implemented and a further action plan would be required. And this, I think you'll see in later reports, is not untypical.

Q. The description, at 2.9, with the Council submitting its agreed action plan; do we infer from that there would have been some comings and goings with the Inspectorate --

A. Yes.

Q. -- as to what the action plan should contain?

A. It's not clear from the record what discussions were taking place. It simply states that the plan had been agreed with the Social Work Inspector.

Q. So what comments then would you make about this particular case study in relation to Dumfries and Galloway?

A. Well, the first issue really related to what would be the Government's response to a poor report, and there were clearly issues concerning Scottish Executive's power to override -- accountability, and that an alternative approach would be better to secure if not immediate action, then action in a reasonable period of time. Public criticism and then the recruitment of consultants to advise the delivery of its functions.

So it's through the press, basically, that you are indicating disquiet and the hope that would be

sufficient to generate a response by the senior managers.

Q. I think we do see in these cases that they do attract significant press coverage.

A. Yes.

Q. Particularly from the local press.

A. Yes.

Q. And we see, for example, in some of the Scottish Government files press cuttings --

A. Press cuttings are displayed to indicate: yes, the point has been made.

Q. Let's move on to the next example. That's Midlothian Council, the period 2007 to 2009. You introduce this by saying:

"The services to protect children in Midlothian underwent an inspection led by HMIe between June and September 2006."

And as you say, as with other joint inspections, it included the range of services provided by Health, the Police, the Local Authority, the Authority Reporter, as well as those provided by voluntary and independent organisations.

When you look at that list, it is a wide list.

A. Yes. We're looking at services to protect children and that obviously covers a variety of local services.

Q. Including the police?
A. Yes, yes.
Q. Again, we have seen this before that a sample of practice files held by the respective agencies were read, and the inspectors met and talked to a number of children and families, as well as to staff who held responsibility for protecting children across the key services?
A. That's right. That's all reported in the published report.
Q. The inspectors also visited services that provided help to children and their families and attended meetings, and reviews were held by the respective agencies. When you read all that, I suppose one can understand, perhaps, why the inspection would take from June -- between June and September?
A. Yes, three months of interviews, reading of files and obviously you are looking at July and August, when there's a summer holiday, and the availability of staff for a meeting, so I'm not surprised it was that length of time.
Q. The report, I think, was published in February 2007, and you set out at 2.3.2 what the findings were; can you just take me through that, Professor?
A. Yes. Three of the 18 quality indicators used

satisfactory, 12 were weak, and three as unsatisfactory.
Q. On the face of it, that looks pretty bad.
A. It does. And the report itself indicates the Inspector was not confident all children that had been identified as being at risk of harm, abuse or neglect and in need of provision were receiving the help and support they needed. And it indicates that work was urgently required to develop clear policies and procedures to guide staff, particularly on planning to meet needs.
Q. Can we see again that the Council and the NHS, and the Lothian Borders Police were asked to prepare an action plan?
A. Yes.
Q. So not just the Council?
A. Because services for children are being provided across a range of services and it's a collective -- it's a collective of agencies, and so they were all required to assist in developing an action plan.
Q. And that was to address the report's recommendations?
A. Yes.
Q. And they were given a time limit as to when this action --
A. 12 months, yes.
Q. It's four months.
A. Sorry four months. And there would be a follow-up

inspection within 12 months to assess more fully the progress with the recommendations. And, again, that indicates a different style of reporting that you have seen historically.

Q. This is an example of Head of the Report's publication, the HMIe submitting a brief --

A. Yes.

Q. -- to the Minister for Education and Young People, and had spelled out, I think, that the findings of the inspection were:

"Highly negative."

So that is the Minister getting an advance notice of a problem?

A. Yes. The Minister was being informed that clearly it's not the quantitative score being used at this stage. It's simply a combination of the qualitative scores indicating 12 was weak and 3 is unsatisfactory, that was below the mark, really.

Q. The same brief, submission contained the description of systemic weaknesses?

A. Yes, in joint planning to meet children's needs resulted in some vulnerable children being exposed to risk of abuse, harm or neglect.

Q. And there is reference again to the proposed action plan.

The Council's Chief Executive accepted the report and the need for immediate action.

A. That's correct, yes. The Minister was informed that officials had met the Chief Executive, the senior managers.

Q. The sentence you have, just on page 54, four lines from the bottom:

"The Minister was also advised that they should personally meet the Local Authority to discuss the report."

And is that his officials, are they the "they"?

A. No, the Minister should meet.

Q. Then, at 2.3.6, are we told that ahead of the meeting with the Local Authority, the Children, Young People and Social Care Group provided a briefing paper for the Minister, setting out the deep concern of the findings and that it was unacceptable for vulnerable children at risk to be not be receiving the support and services they needed.

A. That's right, and the detail of that is the outcome of the meeting with the Minister concerned in.

Q. If we look at 2.3.7; do we see that the council confirmed that it had "unanimously approved implementation measures to address the report's criticism"?

And the Minister acknowledged that.

A. That's right, yes.

Q. You go on to say at 2.3.8, on page 56, that a joint interim follow-through inspection was conducted in December 2007. When you described that as "interim"; is this a prelude to another inspection taking place?

A. Yes. In this particular period -- and I think I explained it in further detail later on -- that you could have a follow-through inspection or follow-up inspection, but prior to that you could have an interim inspection, interim follow-through inspection.

The terminology differs between the social work agency and HMI Education, but it's the same thing. It is basically that you are testing the water to make sure, at an interim inspection, that in fact plans are being implemented before a follow-through inspection, which would involve more staff.

Q. This is the joint interim follow-through inspection in December 2007. We are told that the inspectors commented the positive result to the February 2007 report, and the actions taken on leadership and the direction of change the service provided. But that also a qualification to that, and there is considerable work still to be done.

A. Yes, that's right. It's not explicitly stated what that

work is. But, nevertheless, it's indicated it should continue before the full follow-through inspection.

Q. Although the services, to quote, "were now much better".

A. Yes.

LADY SMITH: So should this interim follow-through inspection, or whatever you call it, be able to have the effect of checking on progress, but making it clear to the Local Authority they were still on their case? To use a colloquialism.

A. Still on their case, and there would be a full followthrough inspection.

LADY SMITH: At some unspecified future point; is that right?

A. Yes, but usually within 12 months, if not 18 months.

LADY SMITH: Thank you.

MR MACAULAY: That happened because I think we're told, in 2.3.9, the joint follow-through inspection was conducted in November 2008.

A. Yes.

Q. What was the conclusion here?

A. Very good progress had been made. If one looks at report in detail, they seem satisfied with the response that Midlothian had taken.

Q. So we see then -- just to get an overview picture here -- that the first inspection was in June to

September 2006.

A. Yes.

Q. We then have the interim follow-through in December 2007 and the subsequent follow-through in November 2008.

A. Yes.

Q. So there are these three inspections over a period of about three years or so?

A. Yes, yes.

Q. Does that tell us then that the Inspectorate was keen to make sure that the deficiencies they identified were sorted out?

A. I think the important issue for the Inquiry is basically that there was sufficient concern that the Minister was informed and, if you like, invited to press the Council to take action. So not just Dumfries and Galloway, but in Midlothian a minister gets involved, so a very high level of ministerial involvement, if you like, trying to ensure that the weaknesses identified in the report are taken on board and followed through.

It is evident that a briefing was given to the Scottish Cabinet at this time and so it was -- the Minister was also reflecting Cabinet interest in the topic.

Q. And as before, at the time of the first inspection, in June and September 2006, we have effectively a snapshot

as to what the position was then.

A. That's right, yes.

Q. But, again, can I ask you to comment on this: would that suggest that this was not a new problem and that it had been an ongoing problem?

A. The implication is that it was an ongoing problem, but it's not explicitly stated in the report itself, because obviously they may not have had all the historical records available to them when they conducted the inspection.

The other important issue to bring out here is that there was significant change in the leadership of the area's Child Protection Services and in the direction of practice. So what you had was a change of policy connected to a change of the management of that policy.

LADY SMITH: Professor Levitt, one of the comments you make in your summary, at 2.3.11, is that matters were looked at in the context of the wider issue of the child protection record in this area in consequence of the death of a looked-after child.

A. Yes.

LADY SMITH: Was that one of the deaths that you spoke about yesterday?

A. No, because this is the second period.

LADY SMITH: So the death had occurred in the second period?

A. Yes.
LADY SMITH: It's not a pre-2005 death?
A. Yes.
LADY SMITH: Thank you. I just wondered whether an earlier death had set the scene for Midlothian being subject to greater scrutiny or greater anxiety.
A. I think that was known before the inspection team conducted the inspection. So they were already alert to the issue of child protection measures within Midlothian Council at the time and if one reads the report very carefully, one can say: yes, we're aware of and, therefore, we need to actually underline the issue of child protection in this particular area.
LADY SMITH: Thank you.
MR MACAULAY: The next case study that you address is for Aberdeen City Council and that council area, and you cover a period of 2008 to 2012.

The inspection that is covered in the May report of 2008 took place, I think, in August 2007 to December 2007. I think I took that from the report?
A. Yes, yes.
Q. Can you just describe what the finding of the inspection was?
A. SWIA's report indicated that of the 10 areas evaluated three were evaluated as adequate, five as weak, and two,

resources and capacity building and leadership direction, were deemed unsatisfactory.

Clearly, the evaluations covered all services, but for Aberdeen's Children and Young People's Services, the report noted that the rate of children whose names had been placed on the Child Protection Register was almost twice the level of Scotland as a whole, and that the strategy adopted by the Council was unlikely to reduce that number.

Q. It is a highly critical report.

A. Yes, yes.

Q. Adequate is the best level that is reached.

A. Yes.

Q. And of the two unsatisfactory levels, clearly leadership and direction would be a concerning factor.

A. And -- yes, leadership and direction, the management, basically, of the services, and the resources available to build up the services. So there are issues of finance as well as leadership.

Q. The placing of names on the Child Protection Register, that was almost twice the level for Scotland as a whole. Of course, I suppose it is the case when you have 32 different Local Authorities that there will be variations --

A. Yes.

Q. -- and different thresholds for actions to be taken?
A. Yes, yes. I think the issue related to the Inspector's belief that the Council strategy would not reduce that number significantly, so it had no policies in place to deal with the issues that placing these children on the register ...
Q. So, the report, if we look at the conclusion of the report:

"There were important weaknesses in the outcomes for a significant number of vulnerable people in contact with and dependent upon the services. These included carers, looked after and accommodated children, children at risk of harm and those with disabilities."

A. Yes.
Q. These were very concerning words.
A. I have clearly taken the section out of the report which deals with the children. There are other sections that also deal with adults and the elderly, but that's one perhaps most pertinent to the Inquiry.
Q. There appears to have been a press leak on report ahead of its formal publication, so I assume from that that the report had been drafted but -- and ready for publication, but not yet published?
A. It had obviously been drafted but someone had looked at draft and leaked it to the press, yes.

Q. What did that cause to happen?
A. There was a pretty quick minute to the Cabinet Secretary for Education and Lifelong Learning, Justice and Health and Well-being, which detailed the issues raised and the recommendations for action. The Cabinet Secretaries were advised that Aberdeen's report was the poorest of the 21 inspection agencies, inspections conducted since the scheme had been introduced, and that the Inspection Agency, on their own authority, had required the Council produce an action plan within three months. And suggested that the Cabinet Secretary should request the inspect agency undertake a follow-up inspection within a year, six months after the production of the city's action plan.
Q. Do we see in the following paragraph that following that submission, the Minister for Children and Early Years, the Cabinet Secretary for Justice And The Minister of Public Health wrote to Aberdeen's Council leader?
A. Yes.
Q. So we have not just one, but three Ministers?
A. Three Ministers, senior Ministers, underlining that the recommendations receive timely and effective response, to ensure the standard of Social Work Services to which they're entitled they receive.
Q. I suppose that would make uncomfortable reading for the

Council leader?

A. Yes and that the Cabinet Secretary and Ministers also indicated that they wished a meeting to discuss the City's response to the report. You are getting quite a very high level of ministerial intervention in this case.

Q. And one would think quite rightly so, standing the nature of the report?

A. Given that on the quantitative scale this was the poorest of the inspection reports to date, one can understand the concern that Ministers might have had.

Q. And did such a meeting take place?

A. I understand that it did take place and again the three Ministers wrote to the City Council to emphasise the early actions required to address the report and that certain management changes took place.

Q. Within the Council?

A. Yes, within the Council.

Q. You tell us then on next page, 59, at 2.4.4, that an HMIe joint inspection was carried out between April and May 2008?

A. Yes.

Q. And again covered a large range of services and staff provided by Health, the Police, the Local Authority and the Scottish Children's Reporter Administration and as

before, looked at files and so on. What was the conclusion here?

A. It effectively restated the Social Work Inspection Agency's concerns that children could be at risk of harm, abuse or neglect and required protection and support. So basically it is underlining the sections in the social work agency report on looked-after children.

I think the important issue to remember here is that the joint inspections looking specifically at Children's Services not just services across the board, so you have one report, part of which indicates a concern about Children's Services and the independent report underlining the concerns almost at the same time.

Q. Again, was there a subsequent joint inspection?

A. Well, there had been discussion --

Q. Sorry. If you go to 2.4.7, the findings you have made reference to did not go down well and if you look here can we see that on 12 January, I think, in 2011, the Minister visited Aberdeen to hear from its Child Protection Services?

A. That's correct. He was assured that significant activity was under way to improve provision of the services.

Q. Can we see that the HMIe joint follow-through inspection was conducted in April 2009. I think --

LADY SMITH: It must be 2009, looking at the footnote, Mr MacAulay.

MR MACAULAY: It is.

A. Yes.

Q. And what then was the results from this report?

A. The follow-through inspection indicate the progress that had been made, the restructuring of services, accepted and shared responsibility across Child Protection Services, but it was too early to evaluate the impact of these changes on practice and outcomes for vulnerable children. Although it decided that no further action would be taken, the next cycle of inspections, a further assessment would be made on the progress on meeting the main points for action in the original report and this was conducted in 2011.

Q. I see that. Of course, in 2009 we are coming to the end of the first cycle?

A. The first cycle so within the second cycle, the targeted scrutiny inspections.

Q. As you say, that was conducted in March 2011 and that confirmed that positive improvements had been made?

A. Yes, yes.

Q. But still work needed to be done?

A. Still work needed to be done, but they were confident that improvements would be made and no additional visit

in relation to the initial inspections would be conducted.

Q. Are we told towards the bottom of the page that the Care Inspectorate's scrutiny report published in December 2012 noted that within Children's Services, discussion of risk that become a key component of staff supervision?

A. That's right, yes, yes.

Q. At 2.4.8, you give your overview of this particular case study. What can you tell us?

A. Firstly that in response to the Inspection Agency's concern, development of children, the quality of services, the Education Inspectorate took the view it should complete its inspection without any delay. Its inspection was on a cycle and now what actually happened here was that they decided to move ahead with Aberdeen more quickly than it would have done as a result of the indicators coming from the Inspection Agency's report.

The officials responsible within the Scottish Government for that area of work, which is now called Workforce Capacity Issues, kept a close overview of the inspections and did advise Scottish Ministers very promptly that urgent action was required to ensure that the points were addressed, and that they took an active role in engaging with the relevant agencies and report's

recommendations.

Q. And getting to where it got eventually, that involved I think management changes?

A. Yes, yes. What you got here like what I've said previously in Midlothian, there were management changes within the services to reflect the need for a different approach.

Q. Again, if I can ask you, we are looking albeit over a period of not just one inspection, but more than one inspection of snapshots of the problems, looking before that, would it be a reasonable assumption to think, particularly if there are problems with management, that there would have been similar concerns?

A. Again, it's not evident from the initial Inspection Agency report, the length of time of concern, but I think it's probably the case that, yes, there were issues and that this form of inspection was bringing those particular issues to light. What you must remember is you had a Social Work Inspection Agency report followed by education inspection joint report, followed by another inspection report to ensure that the remedial action had been taken in Children's Services.

Q. Quite significant input from the Inspectorate to get to where it got?

A. Yes, yes. That's a significant change, if you like, in

this period from, if you like, the previous period.

Q. The next council area you look at is Moray Council and this is over the period 2007 to 2012. And you begin by telling us that the SWIA performance inspection of Social Work Services of Moray Council took place between March and June of 2007 and you set out the levels at which the indicators were at. Can you describe these?

A. Four were classed as good, five as adequate and one as weak. Could I also make it clear that when it says "Moray Council and council area", that is referring to in fact two sets of reports, because Moray Council was being inspected by the Social Work Inspection Agency and Moray Council area covers all services for children and therefore covers the Health Services, the Police Services and Education Services and therefore there are two distinct bodies involved there.

You might have some confusion of what that means, but that is what it means. When it says "Moray Council" it means the Local Authority. Where it says "Moray Council area", it means the joint services.

Q. I see. If we look at the levels: four as good, five as adequate and one as weak, that's certainly much better than we have seen in I think the last case study, quite significantly better?

A. The area classed as weak covered the delivery of key

processes. As I say here, the evaluation over a composite score across all Social Work Services but within the report the Inspection Agencies commented unfavourably on certain aspects of the services for looked-after children and so there was a concern within the report of services for looked-after children.

Q. Do we read also that this included -- the unfavourable aspects of services for looked-after children included service users' perception of the outcomes for children with special needs?

A. Yes.

Q. And also at a higher percentage than the national average of looked-after children placed away from home for more than a year. When you say placed away from home; that could be either foster care or residential care?

A. Residential care, yes.

And the following sentence also: placed in three or more homes, again compared to the national average their educational outcomes had deteriorated significantly. So there were issues of placing the children and ensuring the quality of education provided.

Q. I think the report made a number of recommendations and they would follow that up with what is described as a short follow-up inspection, one year after publication

of the report.

A. Yes.

Q. Do we learn, in the next paragraph, that between June and September 2008, before the SWIA follow-up inspection took place, the HMIe let a joint inspection of services and the results are set out; what were the results?

A. Services rated satisfactory on five indicators, ten as weak and three as unsatisfactory.

Q. That's quite a contrast to the report from SWIA?

A. SWIA were looking across the board, and you must remember they were looking at Adult Services, Mental Health Services, Services for the Elderly, so their report only concerned one aspect, if you like, of Children's Services within the overall. This is looking at Children's Services as a composite service and, therefore, it's looking more in depth at services for children.

Q. It's a poor report?

A. It's, as indicated here, Moray ranked with Aberdeen and Midlothian as the three areas with the poorest quality evaluation since the scheme was introduced in 2006 and that's from the published report.

Q. Among the conclusions of the report, I'll pick up two points. First of all:

"Inspectors were not confident that all children at

risk of harm, abuse or neglect and in need of protection were receiving the help and support they needed."

That is the first point.

A. That's right, yes.

Q. Then we are told a bit more about the lack of rigorous assessment and so on. But then we read:

"There were delays and deficiencies in the identification and investigation of suspected child abuse."

So clearly they were able to identify instances where there was suspected child abuse, where there were, as they say, delays and deficiencies in the identification and investigation.

A. That's right. They were clearly not progressing those particular cases.

Q. Again, do we see that the request was for an action plan in line with the recommendations?

A. That's right, and a report within four months to the extent on progress being achieved. And that another visit, another inspection, would occur within a year, if you like, a follow-through, follow-up inspection.

Q. Do we have some political involvement set out at 2.5.4?

A. Yes. The draft report was read by the Cabinet Secretary for Education and Life Long Learning and they wished a note of the actions being taken ahead of informing the

Cabinet of this report.

Q. Do we read that at the same time the head of division informed the Minister for Children and Early Years that they had met the Chief Constable?

A. Yes, yes, who chaired the North-East Children's Protection Committee and they agreed that action should be taken quickly.

Q. If we go on to 2.5.5, do we learn now that the Minister met Moray's Chief Officers on 13 January 2009 and discussed the draft action plan that Moray had submitted.

A. That's right and the Minister was not assured that the plan was effective and that Moray was asked that the plan should be redrafted and expanded.

LADY SMITH: Again, that is the Minister for Children and Early Years.

A. That's right, yes.

MR MACAULAY: The Minister is clearly taking a proactive role in this.

A. Again, that reflects the quantitative indicator that this was a very poor report and that Ministers were prepared to take action again when you had that level of unsatisfactory and weak performance.

Q. I think we are told, at 2.5.6, that Moray expanded its action plan, which officials subsequently noticed

appeared much stronger with detailed positive action supportive of additional staff time committed to its delivery.

A. Yes. But it appeared to officials within the Scottish Government that the Council had not accepted full and unqualified responsibilities for the failings identified. And it was evident that the Minister remained equally concerned on the quality of care that was being provided within Moray's senior management.

Q. This is one example then where we don't see the compliance that we have seen in previous examples?

A. Yes.

Q. Almost immediate compliance.

A. Immediate compliance for this one. Moray was informed that they could not -- the Council and the support services could ensure its public support for the action plan.

MR MACAULAY: My Lady, I'm going to develop this.

LADY SMITH: Maybe we should break now for the lunch break. We'll stop now and sit again at 2 o'clock, Professor Levitt. Thank you.

(1.00 pm)

(The luncheon adjournment)

(2.00 pm)

LADY SMITH: Professor Levitt, are you ready for us to carry

on?
A. Yes.
LADY SMITH: Thank you very much. Mr MacAulay.
MR MACAULAY: My Lady.
Before lunch we had been looking at Moray Council and if I can take you to page 65 of the report and if you could turn to paragraph 2.5.7. We read there at the request of the Scottish Ministers the HMIe revisited Moray Council area earlier than planned in June 2009 to assess the action plan and the extent of improvement of the services. I think we had seen before lunch there was some controversy of the action plan.
A. That's right, yes.
Q. What was the conclusion here, in the report that was published in October 2009?
A. Before that, could I draw your attention to footnote 208, which is that quote, which appeared in the BBC, and I think it's important to bring up to the Inquiry that this information -- the actions of the Ministers were being published, and so there is no secrecy attached to the failings of Moray Council. I think it's important to actually bring out the level at which these inspection reports ended up in the press.
Sorry, yes.
Q. Carry on.

LADY SMITH: It's interesting.
MR MACAULAY: The report then, in October 2009, I think we can read that overall encouraging progress has been made in a short time.
A. Yes.
Q. Can we also read that there was an increased acceptance by senior managers across services of the need to take collective responsibility for ensuring necessary change and improvement? There were early signs of an increasing focus on the quality of children's involvement in Child Protection Services and improving outcomes for vulnerable families, so that's progress.
A. It's progress, but it also indicates the emphasis given to management and leadership in determining the extent to which the improvements were taking place.
And it's a constant theme, I think, within these reports, the emphasis on the issue of whether the amount was at the right level to ensure Children's Services.
Q. I think the plan at that time was the inspectors would revisit within 12 months?
A. That's right, yes, yes.
Q. Ahead of the report's publication; do you set out that the division informed the Minister that the report showed:
"Encouraging early progress overall in addressing

the serious shortcomings in Moray, although there is still much to be done to improve services."

A. That is correct. And that is a polite way of informing Ministers that much more requires to be done. If you look at that phrase correctly, "Early progress, although there is still much to be done", and I think the emphasis is on "still much to be done".

Q. The Minister was informed that the only area of limited progress concerned the level of interagency discussion on managing the investigation of suspected child abuse. I think we had seen a reference to that in the previous report?

A. That's right, yes. That was clearly one of the principal concerns, that child abuse was not being tackled in that particular area.

Q. Can we see that the Ministerial involvement goes on, because you set out that the Minister met with the division and asked the division to draw up a plan:

"A plan of engagement with Moray Local Authority to ensure its response to the recommendations made in the two reports."

A. That's right, yes. It's interesting to note that the Minister wanted to meet the civil servants who had official responsibility in this matter.

Q. If we go on to page 66, 2.5.10; do you set out there

that there was an HMIe-led joint follow-through inspection in June 2010?

A. That's correct, yes.

Q. What was the outcome?

A. And the outcome is good progress had been made. Services, individually and collectively, had taken forward improvements in important areas, including the use of appropriate legal measures, information sharing between Paediatricians, Social Work and Police. Risk assessment and planning at child protection meetings and the involvement of individual children in decision making.

So that's an indication of what they were looking for, basically, at the local level in terms of tackling the issue of child abuse.

Q. And, again, do we see in the next paragraph there is ministerial involvement?

A. Yes. The Minister clearly wished to be kept informed on the progress that had been made, or not been made. And the Minister was advised that Moray would be revisited as part of the next cycle of inspections.

Q. That inspection, as you set out, was carried out in January 2012.

A. That's right, yes. As a very positive report.

Q. Over the period from the time of the first inspection,

which was in March to June 2007, and the follow-up in June and December 2008, then a follow-through in June 2010, and a revisit in January 2012; do we see, in these four inspections in about four or five years, the progress that's been made?

A. Yes. I think a combination of the inspection reports, official action and ministerial intervention, and press publicity, all seem to have had the right effect, certainly in terms of the revisit during 2011 and 2012.

Q. It appears to be the case that this ongoing pressure from the Inspectorate, and indeed at a political level has created a situation where this council has gone from a fairly unsatisfactory state to an acceptable state?

A. To one being unsatisfactory, at least satisfactory, yes, yes.

Q. Your own review, Professor Levitt, at 2.5.12; can you summarise what you have picked out of this case study?

A. Clearly, a consistency at official and ministerial level in responding to the inadequacies at -- of children services in Moray, Aberdeen and Midlothian.

It's clear that the combination of the Inspection Agency reports and HMIe-led inspection reports indicating the possibility of or probability of -- children could be at risk of harm, abuse or neglect.

And as Aberdeen and Midlothian, officials moved very

quickly to advise Ministers, to press the Council and allied services to take action before the formal publication of the first report.

It is clear that the Minister for Education and Young People accepted the advice and evidently indicated their disquiet at the management of the services being provided.

And it's clear that officials kept Ministers informed throughout the process at appropriate level. And I would say from my experience of looking at a whole range of, if you like, Government documents on different topics, this is exactly what I would have expected.

Where there were issues, you would expect officials to inform Ministers, and you would expect Ministers to issue directions. And I think these -- this is within the usual form of how Officials and Ministers would react to where there were indications of a breakdown in services or whatever it was.

Q. We move on then to look at 2.6, on page 67, and this is Dundee City Council and the Council area and it is a period of 2007 to 2012. You introduce this section making reference to an incident that I think links in to what you say later.

A. Yes.

Q. It's to do with a murder that took place in Dundee in

March 2008?
A. That's right.
Q. What were the circumstances of that?
A. A 23-month-old boy died after a ruptured intestine caused by a heavy blow inflicted by his mother's boyfriend, and the boyfriend subsequently being convicted of homicide at Glasgow High Court.
LADY SMITH: I think it was culpable homicide, rather than murder.
A. Did I say murder?
MR MACAULAY: It was culpable homicide.
A. It was culpable homicide.
Q. It was a blow to the 23-month-old boy's abdomen, I assume, that ruptured his intestine and he died.
A. Yes, that's right. It was a well-publicised case at the time. Considerable press and media publicity in it.
Q. I think you say there was a significant case review established by the Dundee Child Protection Committee?
A. That's right. The death could not have been predicted, although there were concerns relating to the involvement of the statutory agencies, and the provision of care for the boy and the mother. This included the local social work department's lack of knowledge that the mother was involved in prostitution and that she and the boyfriend were heroin users.

Q. I think the significant case review went on to say that the lack of knowledge about the family's circumstances was itself a product of poor information sharing --
A. Yes.
Q. -- and recording to the social work department, NHS Visitors and the local protection -- and the Police?
A. Yes.
Q. This perhaps shows you the importance of integrated working.
A. Integrated, co-ordinated information sharing between the relevant agencies.
Q. I think, looking to the circumstances, the boy was not actually in care at this time; is that correct?
A. The boy was not in care at the time, although the mother, on a voluntary basis, was attending a week day family centre which provided pre-nursery care.
Q. It's an example as to how this system in Dundee was working?
A. That's right, yes, yes.
LADY SMITH: Or indeed not working, because I think you note, Professor Levitt, about the social work department not having found out about the mother being a prostitute, and both she and her boyfriend being heroin users, which would have, one hoped, alerted them to the need to intervene earlier, if they'd known that.

A. It was the lack of knowledge of the relationships going on and the movement of the boy between, as it says here, the parents' house to live with the boyfriend.

And the case conference had been scheduled two days after the boy's death, and that was all within the salient case review papers.

Q. Now then, Dundee was subject to an SWIA performance inspection and that was between March and June 2007, with report published in November 2007.

A. That's right, yes.

Q. What conclusions did it come to?

A. This, of course, was across all Social Work Services and it was generally positive with eight of the ten areas evaluated as good or very good. Two other areas, delivery key processes, resources and capacity building were rated as adequate, which in terms of the aggregate score would mean that this Local Authority Services were regarded as not requiring further enquiry.

Q. The report did however draw attention the high incidence of drug misuse in the city.

A. Yes, yes, and there should be an up-to-date risk register integrated with service planning and incorporating risk management arrangements. That was a general statement, not specifically related to children, but I think that is quite an important

statement within the report; that the at risk assessments were perhaps underpowered, shall we say.

It noted the high incidence of drugs misuse and its attendant family problems, and noted that there had been an internal review by a social work department, indicating that some of the referrals were not actually at the level -- not at that level of urgency for child protection, and that some further work needed to be required in terms of the referral process, and that increased focus should be on high priority cases.

Q. So, at 2.6.4, you say that although report concluded that department and its child protection partners had robust structures and procedures in place for child protection, which included discussion between social work and the Police, and where relevant education, it added -- and then there is a quote you have taken from the report, suggesting that some staff said that Health Services staff were not always invited to attend initial referral discussions.

A. That's correct. So the level of interagency co-ordination was clearly, in terms of existing protocols, not necessarily being followed.

Q. Although I think the senior managers seemed to challenge that.

A. Senior managers seemed to challenge that, but I think

it's important why that statement would have been presented in a report. Clearly, the agency, Inspection Agency, felt: well, there are issues here that we need to report on. And the way that reports are constructed suggests that they had a concern.

Q. That's why they say that the department and its partners should review the operation of these meetings?

A. Yes, yes, yes.

Q. At 2.6.5, on page 69 -- and I ask you this because the report by and large was a positive report.

A. That's right, yes.

Q. But yet it says there that after the report was published the SWIA visited Dundee City Council at quarterly intervals, and I just wondered: what drove that?

A. My assumption is that although this report was seeming to be above the line, there were certainly some concerns, without necessarily specifying what those concerns were. And they wanted to be assured that an action plan was being implemented.

Q. We see that the SWIA conducted its follow-through inspection in December 2008.

A. Yes.

Q. I don't think the report was published until after that. So this is after the killing of the boy?

A. That is right, yes.
Q. What conclusions did they come to, at this point?
A. They noted that the department had implemented the recommendations of a risk register, but that a business continuity plan, although implemented, existed in draft form only.

And the report indicated that it still had concerns about attendance of relevant health professionals at child protection conferences.

Q. Moving on then to the HMIe. At 2.6.7, can we see that the HMIe began its inspection in February 2009, as part of its ongoing programme and, at the request of The Minister for Children and Young People, was asked to complete the report by June 2009. Do you have any insight as to why that request was being made?
A. Certainly it's evident that in fact in draft form the December report had been circulating within the department at least verbally, if not in written form, and that there were clearly some concerns on the issue of Children's Services and child abuse.

And that although the HMIe had begun its inspection in February 2009 at the request of the Minister for Children and Young People, it was asked to complete the report by June 2009. That is after the court case on the boy had been completed.

Q. What were the conclusions from the inspection?
A. Of the 18 quality indicators used to evaluate the overall effectiveness of the service, eight were deemed weak, and one, children are helped by the actions taken, the immediate response to concern was rated unsatisfactory.
Q. Then we go on to read that the report summary stated that the inspectors were not confident that all children who were at risk of harm, abuse or neglect and in need of protection were identified and received the help and support they needed.
A. That's correct, yes. So this is certainly a considerable elaboration from the earlier Inspection Agency Report and considerably in more detail as to the risks of harm to children in the city.
Q. Is this in any way harking back to the death of the boy in March 2008? By that, I mean: would they have that in mind when making these observations?
A. I think that by the time HMIe began its inspection report, it was fully aware of the circumstances surrounding the death and, therefore, given the publicity attached to the death, it was going to scrutinise the services in considerable detail and at considerable length.
Q. It goes on to say:

"Many children who did not receive help until their situation had reached crisis levels."

A. Yes, yes.

Q. So this is critical --

A. Some children were left in situations of risks for too long and without adequate protection or support. Lack of guidance to staff, in terms of policies and procedures and, essentially, risk assessment was clearly amiss.

Q. So the report indicated that an action plan had been requested from the Dundee Chief Officers Group, a senior officer from the City Council, from NHS Tayside and the Police, on how they would address its main recommendations?

A. Yes.

Q. So that had been sought. Ahead of the report's publication in June, 2009, the safer children's stronger families division submitted a minute to the Cabinet Secretary commenting that the HMIe inspection of child services in Dundee had been one of the worst in this round of inspections, although it's not as bad as Aberdeen, Midlothian or Moray.

So a fairly damning report.

A. Yes, it's clearly one of the weakest reports. And it's important to recognise that in fact the Minister was

being informed ahead of the report's publication.
Q. The verbal feedback that was given to Dundee Chief Officer Group resulted in a bit of controversy, I think, because they challenged the question --
A. Well, they had a report which said that things were not ticketyboo, but certainly adequate, and here they have a report which says something contrary.
Q. I think some explanation is given for the difference?
A. Well, the difference is, of course, that the HMIe focus was on Children's Services solely and not across all services.
Q. I think the feeling was -- at 2.6.10 -- the division believed that the Dundee's response to the HMIe recommendations for improvement was not satisfactory?
A. That's right. In effect, the division believed that it was important to inform Ministers that they believed it remained deficient. And 2.6.10 and 2.6.11, indicates that the Minister was clearly concerned enough to phone Dundee and chief officers to discuss the report and effectively insist that swift and effective improvements were implemented.
Q. Do you see that the impact of the telephone call was that the Dundee chief officers accepted the report in full?
A. Yes.

Q. So they had changed tack.
A. Changed tack completely.
Q. Do you tell us then, at 2.6.12, that between 2007 and 2009 services in Dundee for children and young people had undergone the three inspections, a full SWIA inspection of Social Work Services, the follow-up inspection by the SWIA, and the HMI joint inspection?
A. That's correct.
Q. And when we talk about joint inspection there?
A. That means -- that's a term they use. It's HMIe-led inspections, so I think it's given a description that these joint inspections included --
Q. The Care Commission?
A. The Care Commission, Social Work Inspection Agency, NHS Scotland and others.

I think 2.6.12 is indicating that there's an acknowledgement that there were clearly some deficiencies in the agency's reporting, or at least it didn't bring out strongly enough that there were deficiencies and the important thing is it's footnote 234, which was drafted in February 2009 ahead of the formal publication of the SWIA follow-through report and, effectively, ahead of the HMIe joint inspection.
Q. Because you set it out there that the SWIA inspection in 2007 had not led to any evaluation of Dundee's Social

Work Department to speak of -- or unsatisfactory. It commented that SWIA inspectors have also noted, orally, that they considered Dundee's Child Protection Services provision is actually rather good?

A. Yes, yes.

Q. If we go on to 2.6.13, as you pointed out yourself, there was an apparent contradiction between SWIA findings and the HMIe findings.

A. Yes.

Q. Do we see here the explanation for that?

A. An explanation was that SWIA does not duplicate the in-depth child protection focus contained within education inspections. Therefore, child protection was only one part of Children's Social Work Services overall that was reviewed, and that the sole focus during interviews and sessions observed. So you could argue or suggest that it was more of a light touch inspection in terms of Children's Services, or child protection, rather, in Children's Services.

Q. And they seek not to duplicate the work?

A. Yes, yes. It was to avoid duplication, but the issue -- I think that is being brought out in this particular -- footnote 235 -- is that there was clearly a gap between the Inspection Agency's form of reporting and issues that were emerging, and the deeper inspection conducted

by the Education Inspectorate.

Q. Perhaps we can move on to 2.6.16, because we are told there that in August 2009 the Deputy Director for Safer Children, et cetera, submitted a minute to the Cabinet Secretary of the imminent publication of the significant case review.

A. That's right, yes.

Q. And this was in connection with the death of the boy in March 2008?

A. That's right.

Q. Following upon that, was it agreed that HMIe would undertake a follow-up inspection?

A. Yes, yes. Given the state of the report and the weaknesses it had uncovered. That would be expected, I have to say. If you look at the other reports concerning Midlothian, Dumfries and Galloway and, for that matter, Aberdeen, you would expect where weaknesses were uncovered that there would be a follow-up report.

Q. Do we see then that in December 2009 the HMIe inspectors revisited Dundee?

A. Yes.

Q. And in particular to assess its early response to the main points for action in the June 2009 report. What conclusions then did HMIe arrive at on this -- as a consequence of this inspection?

A. I think I would begin that by saying that the normal process was the follow-up inspection within 12 months. But, at 2.40, the interim inspection was in six months, to underline Scottish Ministers' concerns. So you actually had a shortening of time for drawing up a plan and actually implementing it.

It indicated that -- the subsequent inspection indicated they responded quickly, significant progress, positive progress, but it was still at a very early stage, as you might expect after six months. And that there was an acceptance that considerable work was still required for full implementation of child protection measures.

Q. And you finish this section by -- this goes on to 2.6.18, where there was a press statement that commented there was still work to be done.

A. That's right, yes. So, again, you have the Minister indicating their continued concern on child protection in Dundee.

Q. I think the Minister writes to Dundee in the terms set out at the top of page 74?

A. Yes, that's correct. Effectively, reiterating what was being issued to the press at the time.

Q. At 2.6.20, do you set out in November 2010 the HMIe returned to Dundee to assess the extent to which

services were continuing to improve?
A. That is right, yes.
Q. And do you set out there the conclusions that they arrived at?
A. Yes, this is another joint follow-through inspection, which is again unusual to have two such joint follow-through inspections, but indicates again -- underlines the obvious concern at agency and HMIe and also ministerial concern which.

Again, this was another positive report, in the sense that matters were progressing forward, but that they would continue to review, to ensure that the full plan had been implemented.
Q. There is a reference there to a strong commitment to continuous improvement?
A. That's right, yes.
Q. Which suggests that there was at least some distance to go.
A. Yes, that's the official language indicating that there were still concerns.
Q. Then, at 2.6.21, do we see that there was an indication there would be a further inspection as part of the second cycle of joint inspections?
A. That's correct, yes.
Q. That inspection was conducted this time by the Care

Inspectorate, they're now in harness, and published in May 2012?

A. Correct, yes.

Q. What was the outcome here?

A. The response to children in need of protection was significantly improved, and information sharing and recording had also improved, and that more specially trained police and social workers were available to interview children. And that the indicators were such that they were either good or very good.

Q. So your own comments then, Professor Levitt, your overview at 2.6.22, can you just briefly run these past the Inquiry?

A. Yes. Clearly some disparity, as noted in the official minutes at the time, between the Inspection Agency's report and HMIe's report. That was attributed to the focus of SWIA being slightly different to that of HMIe.

Clearly, it wasn't working very well in Dundee, as HMIe indicated, but it's evident that SWIA, if you read their reports, indicated that further work would be conducted through HMIe's joint inspection of services. So, in effect, they were saying in their report: there's another report which we will look at that in further detail.

The joint report, HMIe joint report, contradicted

the SWIA's overall assessment and there to report that fell amongst the worst performing Child Protection Services in Scotland.

It was an assessment in line with the SCR conclusions published later. It is evident that Scottish Ministers clearly accepted the HMIe's findings and, with other negative inspections, pressed the Local Authority to institute an immediate action plan.

And again re-emphasising that in fact instead of 12 months, it will be six months, and that further reviews would take place, indicating -- the final report in 2012 indicating that the standards of child protection was now good or better.

Q. We see in this instance that there is a process of inspection that begins in June 2007 and concludes in February 2012, with the comments that we've seen, the positive comments.

A. Yes.

Q. But, over the piece, it's taken quite a bit of persuading --

A. It's a lengthy period of time for the services to, if you like, improve in the way that was thought to reach the standard, even with ministerial intervention.

Q. Do you consider, having looked at the cases we have looked at so far as examples -- and indeed we have

a couple more to come -- that ministerial intervention does play an important role?

A. Yes, yes. I think when the reports were clearly indicating deficiencies, it is evident that officials following, I would say, in my understanding and my knowledge of such matters, informed Ministers very quickly and advised Ministers they would have to get involved and respond to the issues that were emerging here. And, if necessary, meet the Local Authorities concerned and agencies concerned, and press the fact that they considered the services substandard.

Q. Very well. We're back to Dumfries and Galloway in the next example, 2.7, and it's the Dumfries and Galloway Council area and this is for the period 2010 to 2015; would this be in the second cycle of the inspections?

A. Yes.

Q. Yes. We begin by looking at an HMIe-led inspection of services conducted between February and March 2010, and this reviewed the services provided with the Health Service, the Police, the Council and the Children's Reporter. You set out there the grades for the six areas that were being evaluated; can you just spell these out?

A. Three were rated as good, two satisfactory, and one improvement in performance as weak. No area was

designated as unsatisfactory.

Although the report had concluded that progress was slow in taking forward many of the planned actions since the previous inspection, clear priorities had been identified. They indicated they would not undertake any further visit.

Q. Does that display a certain acceptance that matters were progressing?

A. Yes, that services improved to a level at which the division could brief the Minister on the line to take if the Government was approached for a comment. I think it indicates, again, quantifying qualitative evaluations, the report qualifies as a positive report.

Q. Indeed, in the briefing that was given to the Minister, of what is referred to as "lines to take", we see that the briefing included the last paragraph there:

"The latest inspection report under Dumfries and Galloway shows only slight improvement in the four reference indicators and overall improvements is judged to be weak. The report still qualifies as a positive report."

A. That's right, yes.

Q. Now, the next inspection -- you refer to that at paragraph 2.7.5, and this took place between January and February 2014 and this would be led by the Care

Inspectorate?

A. That's right.

Q. If you look then at the conclusions -- perhaps before we do that, again, can we see the nature of the inspection?

A. I thought it would be useful for the Inquiry to know the very detailed approach that was being taken, reviewing documents, interviewing managers, staff, children, young people and families and observing meetings, reading over 100 records relating to the most vulnerable children and people.

And that is an indication of the depth to which this inspection reached.

Q. I should have pointed out, I think we referred to February, but in fact it took place between January and February 2014?

A. That's over a two-month period.

Q. What conclusions then did the Care Commission arrive at in connection with the quality indicators?

A. Of the quality indicators being used, five were deemed adequate, three classed as weak, and one assessing and responding to risks and needs was deemed unsatisfactory.

Q. And then that's a critical report?

A. Highly critical report, indicating that they were not confident that children and young people were receiving in time effective help to keep them safe.

Q. If we move on to page 276 -- and we have seen this before -- can we see that you have discovered that a month before the report's publication the rights and well-being division informed The Minister for Children and Young People that it anticipated the Care Inspectorate would publish a very critical report into children services in Dumfries and Galloway?

A. That's correct, yes.

Q. So there was a warning?

A. There was a warning to the Minister, with a briefing, which reflected those concerns.

Q. And you set that out in the quote?

A. Yes.

Q. "Clearly these are extremely serious failings and we will expect to see a recognition of this from officials at the meeting on Thursday, as well as requiring an action plan as a matter of urgency."

So that was the level it was at; it was urgent.

A. It was urgent and, as you can see, they were -- this is suggesting that a number of senior individuals within the profession could be able to offer support as consultants, and that the now designated Chief Social Work Adviser would offer assistance. And it's important to recognise that in April 2011 the Chief Social Work Adviser role continued, although that had been combined

with the role of the Chief Social Work Inspector. The inspectorial role had gone to the Care Inspectorate, but the social work aspect of that work remained within the adviser, who remained an official within the Scottish Government.

It might be confusing to see: well, where is this person coming from?

LADY SMITH: We have been here before, of course, in advising Dumfries and Galloway they need expert advice from outside.

A. That is right, yes, bringing in consultants. But, in addition, because the Chief Social Adviser now no longer has any inspectorial functions, they were therefore a free-floating official who could also offer professional advice and, in April 2011, that particular official therefore became free to assist the Government in such matters.

MR MACAULAY: Was he assisting the Government or would be assisting the Council?

A. He was assisting the Government in assisting the Council.

Q. Right, I see.

LADY SMITH: Having become, as you put it, "free floating", he had a measure of independence then?

A. Yes. They had a measure of independence from the actual

inspection and, therefore, could comment critically on the report itself and the measures that Dumfries and Galloway should undertake.

Q. Can we see here that there had been a meeting planned between officials and Dumfries and Galloway's chief officers?

A. Yes. The Minister would be updated after a pre-arranged meeting, and the Chief Social Work Adviser and the Division had met the Council and the interim Chair of the Child Protection Committee. The report's findings had been accepted, and the plan would be put in place to identify case files of the 200 vulnerable children deemed at risk.

Q. You are reading from 2.7.8?

A. Yes.

Q. And just to recap, what was being reported as a matter of urgency:

"The Council indicated that it would put in place a plan to identify the case files of the two hundred vulnerable children deemed at risk on the Child Protection Register."?

A. That's right, yes. And the Chief Social Work Adviser emphasised the Council should ensure an external element in review of the register."

Q. Was that so there would be some oversight?

A. I think that was an indication that the Chief Social Work Adviser viewed that an internal review, given the deficiencies as outlined in the report, would not be satisfactory, that they would have to bring in external consultants again, to review that particular register.

Q. Is this really almost like deja vu in a sense? In that it's not quite a mirror reflection, but --

A. It's a deja vu, except -- I want to stress again there is an important distinction between 2006/7 and this period, that the Scottish Government can field the Chief Social Work Adviser as an interlocker(sic) between itself and implementing the strategy plan that the Care Inspectorate wished.

The Care Inspectorate being, of course, an arm's length body. And it's important to make a distinction, I think, between the earlier report, which was -- the Inspection Agency itself was a member of the Scottish Government, and the Care Inspectorate which was independent of the Government, and the Government bringing in the Chief Social Worker Adviser as a mediator, if you like, in the process and that's an important change of roles.

Q. You are highlighting, I think, the independence of the Care Inspectorate?

A. Yes, yes, yes.

Q. Do we learn in the next paragraph, at 2.7.9, that shortly before formal publication of the report, the Minister was briefed on the report's findings and that the chief officers for Dumfries and Galloway had agreed to meet the Minister?

A. Yes, yes.

Q. Also, at the meeting, I think, of the Child Protection Committee, Chief Officers confirmed they had accepted the report and that an improvement plan was in place and being progressed; is that noted?

A. That's correct. And they acknowledged that the Chief Social Work Adviser had advised on the appointment of new senior staff, and that Government officials would visit the area later in the year to discuss progress.

Q. Thank you for drawing attention to that.

The Chief Social Work Adviser, you described a few moments ago as the mediator.

A. Yes.

Q. Is he advising the Council here then?

A. He's advising the Council from their professional standing as to what was required, and clearly identified a new senior staff should be appointed.

Q. The inference from that is that the senior staff in situ were not up to the mark.

A. That's the inference, yes. If he advised on the

appointment of new senior staff, then the indications are that new senior staff suitably qualified were required to implement the plan.

Q. If we move on to 2.7 -- perhaps just on that. Remind me in relation to the previous inspection -- the first inspection of Dumfries and Galloway was in between January and April 2006. Can you remind me: was there an issue over senior staff and management in that?

A. There was, yes, yes. There was only one qualified social worker looking after children services.

Q. That's correct. We don't know how many are here at this time.

A. No, but 2.7.10 indicates that the Chief Social Work Adviser had visited Dumfries and provided support on recruitment of a new Chief Social Work Officer for the Council. So that's the level at which support was being given.

And that the Chief Social Work Adviser had continued to provide support by attending meetings of the Child Protection Committee.

Q. Is it a surprise to you that the management issues that had been identified way back in 2006 are still around?

A. It's difficult to establish because we don't have, from the files, what management was in place in 2008 to 2012. We have a report earlier, in 2010, which was reasonably

positive. So all one can say is that clearly something had gone amiss between the May report 2010, certainly, and this inspection in 2014. It may well have been staff changes occurring within the Council. I don't know because it's not stated.

Q. If we move on then to the next inspection, if you turn to page 80, 2.7.12; have you set out there, Professor, that the Care Inspectorate undertook its follow-through inspection in December 2014?

A. Yes, this is again indicating that the follow through inspections would occur in such circumstances.

Q. What conclusions was the care -- what conclusions did they arrive at as a result of this inspection?

A. There was a much higher degree of confidence that the issues that had been emerging were being taken seriously, and at least had started to put the right people in place and moving at a pace which indicates they were appointing staff, appropriately qualified staff, within the service.

Although they identify the continuing challenges, there was, if you like, a positive spin on the report, but indicating that the CI would continue to monitor progress and conduct a further inspection or review within 18 months. So you are having three inspections, one inspection followed by two follow-through

inspections.

Q. Then you make a number of points in connection with this particular case study that you think are relevant to have in mind; what are these points?

A. Well, this report was one of the most critical since the new scheme had been introduced in 2012. The response by Officers and Ministers was swift, insisting on remedial action, and that Ministers pressed the appointment of an improvement team to assist in the protection of children and meet their needs. And that contact was maintained with the Council over the period, to ensure that the agreed action plan was on track; not just the Care Inspectorate, but officials and also the Chief Social Work Adviser had kept tabs on what was going on.

Q. The next council that you consider is Clackmannanshire Council and Council Area.

A. Yes.

Q. And that's the period 2008 to 2014. As you tell us, at 2.8.1, the services to protect children in that council area underwent an inspection by the HMIe between June and September 2007 and, as we have seen from other joint inspections, it included the range of services provided by Health, Police, Local Authority, the Authority Reporter, as well as those provided by voluntary and independent organisations.

Just on that, do we see examples of that from other cases, namely that voluntary and independent organisations are also involved?

A. I would have to look the actual reports. I'm just basically quoting verbatim from the reports. My understanding is that similar text, perhaps slightly differently worded, was inserted in all these reports.

LADY SMITH: Yes, I think you mentioned voluntary and independent organisations earlier, Professor Levitt. But we haven't seen any specific mention of what they did or what their input was.

A. Yes. The actual reports don't say very much. They simply indicate that's what they're going to review.

Q. Again, we have narrative that a sample of practice files held by the respective agencies were read, and the inspectors met and talked to a number of children and families, as well as staff.

A. Yes. It's the same format.

Q. It's the same format.

A. Yes, yes.

Q. As a result of the inspection then; what conclusions did HMIe arrive at?

A. Of the quality indicators, 18 qualities were classed as good, six as adequate, eight as weak, and one effectiveness of planning -- planning to meet needs,

unsatisfactory.

And, again, it's a phrase that was used in other reports:

"Inspectors not confident all children at risk of harm, abuse or neglect and in need of protection have been identified early enough to receive the help and support they needed."

Q. So that is quite critical then --

A. It's extremely critical, yes, yes.

Q. Can we see that the results of that is that Clackmannanshire's Chief Officers from the District Council, the NHS, Forth Valley and Central Police, as well as members of the Clackmannanshire Child Protection Committee --

A. Sorry, they were members of the Clackmannanshire Child Protection --

Q. Quite right, as members of. They were asked to prepare an action plan to address the report's recommendations and to submit a report, again within four months.

A. On the progress of its implementation.

Q. Yes. We find as we move on that ahead of the report's publication, the Minister for Children and Early Years met the Clackmannanshire Council leader to -- and officials to discuss the report.

A. Yes.

Q. Again, it's a similar pattern.
A. It's a similar pattern that clearly this is a highly critical report and the Minister is being advised by his officials that they should intervene. The Minister being told it scored so poorly on 18 of the indicators used.
Q. Have you set out that it was noted that the Minister used the meeting to be reassured --
A. Yes.
Q. -- that the Council accepted the report?
A. Yes.
Q. And was taking steps to implement the action plan sought by the HMIe?
A. That's right, yes.
Q. Here I think the Minister indicated that they would seek a progress report within six months?
A. Correct, yes.
Q. Do we read on then that the SWIA -- we're now back to SWIA --
A. Yes.
Q. -- performance inspection of Social Work Services of Clackmannanshire Council took place between November 2007 and March 2008; what were their findings?
A. Obviously, this was a composite score across all Social Work Services, but the SWIA commented unfavourably on

certain aspects of services for looked after children. Noted the conclusions of the Education Inspection Report and confirmed that an external consultant had been appointed to assist with the action plan that had been recommended.

SWIA did not seek to replicate the HMIe's review of child protection procedures, but it commented that they were given a comprehensive format for risk assessment for child protection, "but we did not find there was a consistent use of risk assessment framework for child protection cases". Then it found there were deficiencies when it did look at some of the cases that it read.

Q. So this inspection by the SWIA takes place between November 2007 and March 2008. I think we'd noted that the HMIe inspection had been shortly before that, June and December 2007?

A. Yes.

Q. Do we see here the two Inspectorates carrying out separate inspections fairly close in time?

A. Fairly close in time. But, of course, there is an important distinction between the SWIA's cycle of inspections of all Local Authority Social Work departments and HMIe's cycle of inspections on Children's Services.

Of course, SWIA's programme would be determined by the agency itself. Whereas, HMIe's programme of inspections were originally determined by the directorate, as I mentioned before, within HMIe itself. And there may well have been some discussion as to when each other was going to conduct their inspections, and there are some discussions -- some of the reports, yes, we're having to borrow inspectors from Social Work Inspection Agency to help us, and Social Work Inspection Agency indicating they were borrowing some Education Inspectors to assist with their inspection.

Q. Can I ask you what might seem a rather stupid question? Would these Inspectorates be based in the same building?

A. No. I'm not -- I think the Social Work Inspection Agency were based in Edinburgh, and I think HMIe was actually based in Livingston.

LADY SMITH: Would that be a good point to stop for the afternoon break? We'll pause now for five or ten minutes and then carry on with your evidence after that, Professor Levitt.

(3.05 pm)

(A short break)

(3.15 pm)

LADY SMITH: If you're ready, we'll carry on, Professor Levitt; is that okay?

Mr MacAulay.

MR MACAULAY: Now, before the break, Professor, we were looking at Clackmannanshire and the HMIe inspection that was carried out in June and September 2007. I think we saw that it was not a positive report.

A. No.

Q. But, in relation to the allocation of looked-after children to a social worker, which you talk about at 2.8.6, bottom of page 82, towards the top of page 83, when team managers allocated work within a geographical area and when we asked the childcare managers to confirm the scale of unallocated work, they had difficulty of doing so, which didn't give one confidence.

A. Not a lot. There seemed to be some confusion, really, about the pattern of work, what was an allocated case. And there was clearly inconsistency in the collation of information on such cases and, therefore, the efforts to review and prioritise unallocated work.

The experience of reading files of child protection cases indicated that some young people were waiting many months for a service.

Q. And this is the SWIA --

A. Yes.

Q. -- Report?

A. Yes.

Q. Then, if we read on, what we read is that SWIA indicated that there would be a follow-up inspection --

A. Yes.

Q. -- one year after publication.

But then we look at the HMIe position, and it conducted the interim follow-through inspection in November 2008, and that was published in 2009; what conclusions did HMIe arrive at?

A. I would want to bring out it was an interim follow-through inspection.

Q. You are quite right.

A. Not just a follow-through inspection, which indicates the severity with which they guarded their original report. It's indicating significant progress had been made, and the main points of action, but that limited progress had been made with the full involvement of health and medical staff in relation to child protection concerns.

To some extent, this reflected the issue in Dundee as well, if you remember Dundee?

Q. Yes.

A. And they would revisit the area to assess further progress within 12 months, ie a further follow-through inspection.

Q. But the point is made that the report did not meet the

requirements set out in the National Performance Framework for a positive report.

A. Correct, yes.

Q. At about this time, when report was published, do you set out that the divisions, say for children's -- Stronger Families Division submitted a briefing to the Minister on the progress that Clackmannanshire had made since the first report and indicated significant work was still required to improve services.

A. Yes, yes, and the Minister clearly indicated that he shared that concern, and what could be done to stimulate progress.

Q. What was done, I think, was to set up a meeting between the Minister and the Clackmannanshire Chief Officers Group in June 2009?

A. Yes.

Q. What was the outcome of that?

A. The Division's briefing indicated that it was necessary for Clackmannanshire to improve its services, and that it held the fourth lowest average score of inspections led by HMIe to protect children in Scotland. So, again, you are getting a quantitative score on qualitative measures, which, from my background, is a bit iffy, which nevertheless is what they were doing.

Q. Do we see then that we're now back to SWIA, that they

revisited Clackmannanshire for the follow-up inspection in September 2009?

A. Yes.

Q. And what did it find?

A. That the Quality Improvement Officer in Childcare had been appointed to further the issues surrounding risk assessment policies and procedures, and that the Lead Officer for Child Protection updated staff on the HMIe action plan.

Yes, it indicated that child protection assessments had improved, there was more focus on assessment training, but it was only just beginning and there was an acknowledgement that more work needed to be done.

Q. So it seems to be a fairly slow progress?

A. It's progress, but it's work in progress. Yet again, one has to say.

Q. At 2.8.12, the report did note that Clackmannanshire had provided evidence of progress in meeting its 2008 recommendations, but the SWIA noted that the pace of progress had been variable.

A. Yes.

Q. Do we see then that the HMIe conducted its full interim follow-through -- now, you call this a "full interim follow-through inspection"?

A. Sorry, I'm quoting from the text. But it's an

interim -- yes, it's full interim, as opposed to an early interim.

Q. And that was in 2010?

A. Yes.

Q. What conclusions did the HMIe arrive at, at this point?

A. They appeared to be satisfied that significant progress had been made, and that as a result of the visit they would not undertake any further visits in connection with the recommendations set out in the 2008 report.

Q. Was there a briefing sent to the Minister?

A. Yes, the Minister was informed. I have to say, I would have expected the briefing to have occurred, to indicate the outcome of the inspection, and that it indicated a positive report, indicating progress towards fulfilling the Scottish Government's undertaking the National Performance Framework to improve the proportion of local authorities receiving positive inspection reports.

Q. I think the Minister was intending to send a letter to --

A. Yes.

Q. -- to say that overall improvements had been made.

A. I couldn't find the actual letter being sent, but a draft letter was there written.

Q. Now, if we look at 2.8.16, we see that in October 2011

the Care Inspectorate produced its scrutiny report on Clackmannanshire?

A. Yes.

Q. What conclusions did the Inspectorate arrive at?

A. It encompassed all Social Work Services, but began its review of Children's Services from the previous HMIe 2010 report, indicating that the Council needed to strengthen assessments of risk and needs and improve plans for children.

But it raised a concern on the implementation of the plan. The pace of implementing needed to be improved.

Q. And was there also an issue over the training of staff?

A. Yes, yes, which again we have seen in other reports.

Q. At 2.8.18, you draw attention to the Care Inspectorate's concerns being underlined by criticism made by Sheriff David Mackie and this was in connection with an appeal against Clackmannanshire's removal of a child from their family.

A. Yes.

Q. What did the Sheriff have to say about this case?

A. There had been a dereliction of statutory duty by the Local Authority to safeguard the child's welfare and referred to culture of poor recording at all levels in the Social Work Department, and absence of rehabilitation planned for the parents.

So the criticism was that the child had been removed and alternative provision could have been offered had Social Services considered a rehabilitation plan to work with the parents, rather than move the child.

Q. Being moved?

A. Yes.

Q. And, perhaps unsurprisingly, as footnote 296 tells us, this was picked up by the Alloa Advertiser?

A. That's right. Again, it was in the press.

Q. In that context, can we see that the Minister asked the Chief Social Work Adviser to discuss the issues of service delivery with the Clackmannanshire's Chief Executive?

A. Again, I think it's important to note that the Chief Social Work Adviser was being used as an intermediary, free from their inspection duties.

Q. Also again in May 2012, in regard to the Care Inspectorate report.

A. Yes.

Q. Do you tell us that following the involvement of the Chief Social Work Adviser in June 2012, the Minister took part in a telephone conference on the Council's commissioned Independent Review of Childcare, Looked-after Children and Child Protection Services?

A. That's correct, yes.

Q. It was after that the Council submitted an improvement plan; is that right?
A. That's correct, yes.
Q. Can you tell us what is happening here then? This has moved on from the criticisms, I think, that the Sheriff made.
A. I think what you have here is that the Chief Social Work Adviser obviously has some continuing concerns and, therefore, continues to act as an intermediary, if you like, between general inspection services, the judgment of Sheriff Mackie and seeking to develop an improvement plan to the Scottish Government. And that further discussions took place with the Minister, with the Chief Social Work Adviser, and Clackmannanshire's Chief Executive during the period August 2012.
Q. Can we see that the Minister agreed that officials would support the Council --
A. Yes.
Q. -- with its improvement plan, and that would involve a combination of informal weekly visits by the Care Inspectorate; is that correct?
A. That's correct, yes.
Q. And the use of consultants from the Centre for Excellence for Children's Care and Protection, CELCIS?
A. Yes, which had recently been established.

Q. Yes. Quite significant involvement being passed, as it were, through the Ministerial route?
A. Yes, yes. But, again, that's an indication that where in fact a report indicated severe issues, the Minister would get involved and, again, I would have been surprised if the Minister had not been involved in some shape or form, even if it was only to press the case on the advice of the Chief Social Work Adviser and their officials.
Q. Then, at 3.8.20, you draw attention to the next Care Inspectorate-led inspection for services for children and young people in this area, and that took place between January and February 2014.
A. Yes.
Q. How did this work out?
A. Of the nine quality indicators evaluated, three were rated as good, five as adequate, and one, assessing responding to risks and needs, as weak. And I think that's really important when you are dealing with risk assessment of child abuse.
Q. What conclusions did the Care Commission arrive at?
A. Whatever the improvement plan had planned had not necessarily been carried out; that there were still important weaknesses in response, initial response to children and young people in need of protection and

process to assess risks and needs. And that some children were placed at risk as a result of that.

Q. Did the Care Inspectorate then indicate that it did expect an action plan --

A. Yes.

Q. -- detailing how Clackmannanshire would deal with these problems?

A. That's correct, yes.

Q. And the plan was to have another visit, another inspection, within a year.

A. Within a year, with the usual follow-through inspection.

But you can note that interestingly, again, some eight weeks before the publication of the report, the Minister was informed that one of its officials and the Chief Social Work Adviser had visited the Council to discuss the report, as he was aware that the report would be critical. And, again, that the Council would benefit from additional support through use of consultants to understand the high child protection rates, the referral, and what to do about them.

Q. The Minister is then briefed formally on report?

A. Yes.

Q. And told:

"You will be aware that the Scottish Government has been working with Clackmannanshire since it faced

a serious crisis of incapability in 2011."

It goes on to say:

"The plan is well underway and significant system rebuilding has taken place, but our view is that the past 18-24 months have effectively been a period of stabilisation."

So it's not hugely positive?

A. It's not, no. That's a polite way of saying that we still have some concerns; although a plan is in place, we need to continue to support it.

Q. If we move on to page 89, at 2.8.26, I think there we have the Care Inspectorate's follow-through inspection, May 2015.

A. Yes.

Q. With a team, we're told, of inspectors from the Care Inspectorate, Healthcare Improvement Scotland and also His Majesty's Inspector of Constabulary?

A. That's right, of Scotland, yes.

Q. What conclusions were arrived at from this inspection?

A. They appeared to be happy that the improvements had an impact on improving the outcomes which were for young people and had yet to show. But they were beginning to show improvement experience of the young people and their families. But they had sufficient confidence in the services capacity to maintain their present rate of

progress.

Q. So to arrive at that point, again we see significant input at a ministerial level and at an inspectorial level.

A. At an inspectorial level from the Care Inspectorate, but also from the Chief Social Work Adviser.

And I think it's important to recognise, after 2011, this was not a free-floating individual, but clearly a senior professional who was located within Scottish Government, who could provide advice and act as an intermediary between an autonomous non-government body, such as the Care Inspectorate, and the results of the inspections.

Q. So then we come to your overview at 2.8.28. Perhaps you can just quickly take me through that?

A. Yes. I think it underlines what I've said in the previous sections about the official and ministerial approach to responding to issues of the quality of Children's Services and Child Protection Services.

It's evident in these reports that there were considerable concerns on the quality of risk assessment procedures in place in this authority, and subsequent reports continued to have concerns.

Nevertheless, following these reports, officials moved quickly to advise Ministers on the necessity to

press the Council and allied services to implement the recommendations. And, yes, it was certainly the case that Ministers accepted the official advice and took an active role in discussions with the Councils.

Q. I think what does come out of the cases we've been looking at, just the extent to which Ministers do take an active role.

A. Yes.

Q. Perhaps, as members of the public, we don't fully realise that, but we certainly see it writ large here.

A. You certainly see it. And once you put them all together and once you realise that press statements are being made, but they're not necessarily in each regional press, but once you add them together, Alloway press, BBC, and so on, you begin to see, yes, a picture emerges where in fact these particular poor performing councils, the reaction is pretty instant and Ministers take on the advice provided by officials and do talk to councils and allied services.

LADY SMITH: Are you saying that the arrival of media interest in the performance of Local Authorities in this area had some impact in sparking Ministers' interests?

A. I would say that it assisted Ministers. It assisted officials in ensuring that Ministers were aware and ensuring that in fact action plans could be implemented.

LADY SMITH: And they couldn't put things on the back burner.

A. It would not be on the back burner, no, no, no, no, no.

MR MACAULAY: Then, at 2.9, Professor, you set out your overall review of this section; can you quickly just pull that together, and what is your overall review?

A. As I said at the beginning of this section, this section deals with where there were poor reviews and where there was sufficient material from the files, the electronic files, to provide some discussion points.

It's clear that these were quality evaluations that were not positive, and although the majority -- and if the Inquiry so wants I can produce material actually which was collected at various points, which indicates the majority were fine, and I think it might be in the papers that were sent to you already. I'm sure there are -- I can get the reference. There are various papers sent to Ministers which basically says that these councils are fine, but these particular councils, these particular areas are not particularly good and, therefore, we have concerns.

I think the first point is there was a reluctance for direct intervention. The policy, perhaps going back some time, was to -- going back in time, to combine public criticism, couched in terms of support for

an action plan, and an encouragement to recruit consultants to advise on practice reforms.

It was certainly the case, at the end of the period, there was a centre established to provide that advice, Strathclyde University.

It is clear the inspecting agencies acknowledged and followed up each other's work, and can be seen by SWIA's reference to earlier education reports of Clackmannanshire's, and the Care Inspectorate's scrutiny reference to HMIe's report on the previous authority in 2010.

The official was certainly advised -- if not in full draft form, certainly verbally -- of pending inspectorial reports that were less than positive, to advise Ministers to take appropriate action. And in fact Ministers, as I said, were prepared to intervene directly and support the actions that had been recommended, and it is certainly the case that where you had clear concerns that Ministers remained strongly committed to the welfare of looked-after children in this particular period, where there was evidence of poor service provision and that children might be at risk of abuse.

Q. Next section of your report, you look at residential schools in the period that we're looking at, 2005 to

2014. You begin, at 3.1, by looking at mainstream independent and local authority schools and schools for pupils with additional needs during that period.

A. Yes.

Q. We may have touched on this already, but you say, in 2005, there were over 50 schools that provided school care accommodation whether on a full-time, term time or weekly basis; those are schools for pupils with additional support needs?

A. That's correct, yes. That's taken from the directory, which was published and is available online, so there's nothing particularly confidential about that.

Q. You provide some information about the locations of some of these schools?

A. Yes.

Q. If we move on to page 92, you are addressing, halfway down the first paragraph, the inspection regimes. In relation to these schools in particular; just remind us what was the inspection regime during the period that we're now looking at?

A. For ASN schools?

Q. Yes.

A. They were subject to inspection, clearly, by HMIe, as it was then formed, and they were subject to inspection by the Care Commission, following the 2001 Act, from April

2002.

They were, therefore, subject, certainly by the Care Commission, to inspection twice per annum. Inspections by HMIe were less frequent intervals, but were usually at four-year intervals, every four years, although mainstream schools were much longer.

Q. If we are looking at frequency of inspection, if you move on to page 93; do you say, at 3.1.5, in 2008 the HMIe altered its inspection policy?

A. That is correct.

Q. For all mainstream schools?

A. Yes.

Q. Including those that provided school care accommodation instead of the previous policy of inspecting schools on a (inaudible) basis, the HMIe and later ES -- that's Education Scotland, is it?

A. That's right.

Q. Inspected a small sample a year. So what is the change here?

A. The change is the assumption that unless there was other intelligence, there was no necessity to conduct a full inspection, including welfare inspection, at regular five-year intervals.

Q. Do you contrast that approach with the schools for additional support needs?

A. That's right, yes. Where there were additional support needs it was clearly evidently felt that the vulnerability of children was there with significant additional support needs and, therefore, some review of their provision at more frequent intervals was necessary.

Q. In relation to --

A. And I think it's important to note what I've said about governance. 3.1.6, the second and third sentence, end of the third sentence.

Q. That is where you say the increased inspection was intended to provide the school with additional support and advice, including on governance?

A. Yes, that's a Board of Governors. You may remember the discussion we had earlier on, Donaldson's Board of Governors?

Q. Being somehow detached from --

A. Yes.

LADY SMITH: Not appreciating the extent of their responsibilities.

A. That's right, yes.

LADY SMITH: I see, in 3.1.5, you rightly note that having gone to sampling you could get Merchiston Castle School having an inspection in 2000, 2003, but then nothing until 2014.

A. Yes.
LADY SMITH: That was picked up as a potential problem and when we looked at Merchiston Castle in the boarding school case study.
A. Some schools, I have noted, were not inspected at all in this period.
MR MACAULAY: You say there, in paragraph 3.1.6, that a link HM Inspector was allocated to every school and you say whether mainstream or a school for additional support needs.
A. Yes, correct.
Q. I think we touched upon this before, but the link HM Inspector would be attached to the HMIe Inspectorate?
A. Yes, yes. There would be an Education Inspector.
And as I think I've indicated in other areas, there was a social work Link Inspector, Care Inspector Link Inspector, there was also an Education Link Inspector, and that was there so, if there was an issue, the school could telephone or email, or whatever, if an issue arose to provide advice.
Q. In relation to registration, 3.1.7, registration was within the jurisdiction of the Registrar of Independent Schools?
A. Yes, considering the registration and providing advice to Scottish Ministers whether to register or not.

Q. At 3.1.9, you remind us of a point you have already made, that the Care Commission, when it was set up, assumed the responsibility from the previous Local Authority Registration Units of registering and inspecting residential schools?
A. Yes.
Q. And in that, they were assisted by the HMIe which inspected and reported on the quality of education in such schools; is that just residential schools generally or are you looking at additional support --
A. No, all schools.
Q. Can I just be clear on this point: in relation to what had been the welfare jurisdiction of HMI; where does that jurisdiction now lie?
A. Fudged.
Q. Pardon?
A. Fudged. The Care Commission had certain responsibilities. HMIe still had certainly responsibilities for the care and welfare of residential pupils, so there was an overlap.
Q. What about when the Care Inspectorate came on the scene?
A. All those, as already said, 18 HMIs moved to Care Inspectorate and they took on the lead for the Care Inspectorate in terms of what had been, if you like, joint inspections.

Q. So they are fudged when we have the Care Commission, but when the Care Inspectorate takes over from the Care Commission, in 2011, in so far as HMIe is concerned; what inspectorial jurisdiction does it retain?
A. A general. And we'll see when we look at one case later on, that "general" becomes slightly more active.
Q. Clearly, being within education they would have a jurisdiction in connection with matters relating to education?
A. In teaching and learning, yes. But I think we'll see that there is an element of not fudge, but overlap of jurisdiction.
Q. We'll come to that.
A. Yes.
Q. If we turn to paragraph 3.1.10, on page 95, you talk there about the cycle of integrated inspections for assisted support needs schools?
A. Yes.
Q. And that was set at four yearly intervals?
A. Yes.
Q. I want to ask you about this document you make mention of on page 96, 3.1.11, and this is the memorandum of understanding that you mention between the Care Commission and the Scottish Executive; can you just tell me about that document?

A. The issue related to the registration of independent schools, whether ASN or not, and the issue surrounded the information that could be supplied by the Care Commission as a result of its inspections, where there were any concerns they would inform the Registrar of those concerns, which might lead to advice to Ministers on the issue of registration or deregistration.

Q. The purpose of the memorandum of understanding was to share information?

A. To share information, yes. Clearly, the Care Commission had within its power certain statutory duties about deregistering the care element of a school. The Registrar had an overview of the registration issues, which it combined education provision, the buildings, the quality of teaching and the care provision provided. And that followed from the 2004 Act. So you had -- the Registrar's remit had expanded to uncover an area of work in which the Care Commission was working.

So if the Care Commission said that the quality of a pastoral care is inadequate that might have impacted on the registration of a boarding school, independent boarding school. And that's why they began to work on a memorandum of understanding, so that the care -- the Registrar might have information about the school from HMIe, which they would then pass on to the Care

Commission, which the Care Commission would take into account in its six-monthly inspections.

One of those inspections would be unannounced, of course; one would be announced and one would be unannounced. So it's that way of saying that integration of regulatory regime for the relevant services. So you don't have the Care Commission saying: we're going to deregister this school for boarding facilities.

And the Scottish Government being completely unaware.

Q. The same applied to the service of an improvement order?

A. Yes.

Q. Essentially, it's one way of the left hand knowing what the right hand is doing, basically?

A. Absolutely, yes, in anticipation. You can't have two regulatory bodies acting independently where there are serious concerns.

Q. If you move on to page 98, 3.1.13 --

A. Could I just go back? It's the last sentence there as well. It was not a legally enforceable contract; it was a working relationship. Without contradicting the Care Commission and the Education Department's respect to statutory responsibilities. So it's a working relationship, rather than a legally enforceable --

LADY SMITH: It was a memorandum of understanding, and the language you quote is routine at the opening of MoUs.

A. Yes.

MR MACAULAY: I was going to take you to what you say on page 98, at 3.1.13. I think you have probably covered this, but what you say is:

"The memorandum was thus a comprehensive statement, which outlined the independence of the Care Commission as a non-governmental public body. But, at the same time, where shared information was necessary, to respect the statutory rights of Scottish Ministers in approving the removing of a school from the register of independent school."

A. That's right, yes.

Q. Can I just ask you about this next paragraph, and what you refer to as the "traffic light system"?

Because what you say there is that following the memorandum, the schools division entered into discussion with HMIe and the Care Commission on the introduction of traffic lights for the use of the Registrar of Independent Schools after the publication of an inspection report including integrated HMIe and Care Commission reports.

Can you explain what this system was designed to do?

A. My feeling is "traffic lights" should be in enclosed

apostrophes. Sorry, I've taken that from official documents.

That was designed to ensure that the Registrar was fully aware where issues were emerging that required some action, immediate action, and absolutely red-hot action, which would have to go to a Minister, where there were serious deficiencies in the quality of education and the care being provided to pupils.

Q. Would this be the system used by Inspectorate? By that I mean the HMIe and the Care Commission?

A. It was certainly to be expected to be used by HMIe in informing the Registrar of where there were issues. It must be remembered that the Care Commission were an independent body; whereas at this stage HMIe were an agency of the Scottish Government and they would be interacting with officials within the Education Department, one of whom was the Registrar.

LADY SMITH: When you say "this stage", we are about 2008?

A. Yes.

MR MACAULAY: When we come to 2011, we have the Care Inspectorate, which is an even more independent body.

A. Even more independent body, yes.

Q. Because it's a body corporate.

A. It's a body corporate, but my understanding is that memorandum continued to be in place.

Q. If we look at your summary of this introductory section for residential schools, at 3.1.16, on page 99; can you perhaps just go through that for me?

A. Yes. Clearly, in this period, all residential schools were regulated and inspected by the Care Commission and, after 2011, the Care Inspectorate.

Care Commission and Care Inspectorate was required to follow the Regulation of Care (Scotland) Act 2001, and the regulations which followed the Act and the National Care Standards. Such standards applied to all residential boarding schools, whether mainstream or ASN. And all independent and Local Authority schools, boarding schools, were subject to inspections by HMIe. Such inspections were designed to assess the quality of education as well as how well the pupils were cared for and treated.

Independent schools were also required to be registered with the Scottish Executive, Scottish Government's Registrar of independent schools, as previously, who at the registration of a new school and before recommending a registration to a Scottish Minister, would consult HMIe and Education Scotland on the plan of educational provision supplied by the school.

All residential schools, boarding schools, were

subject to integrated inspections by the Care Commission and by HMIe. Such inspections were intended to cover residential provision, including the environment, care and protection, and support.

ASN schools, the inspections were also aimed at indicating the partnership working between the various statutory authorities for the well-being of pupils.

Clearly, the issues surrounding ASN schools meant inspections would incur at more frequent intervals.

Q. I think in the remainder of this section what you do, as you've done before with Local Authorities, is you look at particular schools that may be of particular interest to highlight the different approaches.

A. Yes, yes.

MR MACAULAY: My Lady, that is 4 o'clock. I have warned the learned Professor that he will not finish this report in the time allocated, and that he would be required to come back at a point that is convenient for all.

LADY SMITH: We can discuss that.

Was that amber, green, red? A warning.

I'm sorry, about that, but you have so much learning to share with us, I think that's the problem.

Very well. I'll rise now for today and sit again at 10 o'clock tomorrow morning. Thank you.

(4.00 pm)

(The Inquiry adjourned until 10.00 am
on Thursday, 1 June 2023)

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