Wednesday, 14 June 2023

(10.00 am)

Professor Ian Levitt (continued)

LADY SMITH: Professor Levitt, welcome back and thank you very much for making arrangements to be back here today.

You know where we are --

A. Yes, I think I do.

LADY SMITH: -- with your very valuable evidence. If you are ready to carry on, I will simply hand on to Mr MacAulay and we will take it from there. Is that all right?

A. Yes, thank you.

MR MACAULAY: Good morning, my Lady.

Questions from Mr MacAulay (continued)

MR MACAULAY: Good morning, Professor.

Last week we had started to look at the section or chapter dealing with residential care and you had taken us through the background to the case studies that you set out in your report. I think you made the point that all residential schools, whether Local Authority or independent, are subject to the same inspection regimes, either by the HMIe or ES as they became, the Care Commission or the Care Inspectorate as it became?

A. That's correct, yes.

Q. I think we will see evidence of that in the case studies

that you set out?

A. Right, yes.

Q. Can we begin then by turning to page 100, that is the pagination at the bottom right, and the first case study you have regard to is Gordonstoun School, near Elgin?

A. That's correct. Could I explain the approach to the collection of samples?

Q. Please.

A. The primary aim was a combination of reports that certainly caused some concern within the administration and were considered by Ministers.

The second was the issue of, if you like, the quality gradings that schools received.

Q. Yes.

A. Really, apart I think from Gordonstoun, some of the other schools that are mentioned in this section of the report, there were quite serious concerns about.

Q. Yes, and then if we look at Gordonstoun, I can tell you that Gordonstoun has already featured in the Inquiry as part of the boarding schools case study, so I think there is some knowledge about the background to the school.

A. Yes.

Q. You begin on page 100, moving onto the following page, in identifying positive reports --

A. Yes.
Q. -- from the inspection point of view.
I think, as we have seen with other fee-paying schools, some upgrading of the accommodation was identified?
A. Yes, that's correct, yes.
Q. This landscape is blotted somewhat by what happened in about May 2009, and you address that at paragraph 3.2.6, where a teacher, a languages teacher, was suspended for revealing in emails the topics that would appear in the forthcoming exam?
A. That's correct, yes.
Q. Unfortunately for the school that was an issue that was widely reported in the press?
A. Yes.
Q. What was the upshot?
A. The upshot was that the Registrar for Independent Schools, after an inquiry, and in connection also with HMIe, reviewed the matter and was satisfied that the principal and the school had acted appropriately and promptly in dealing with the matter.
Q. Is this another example of particularly when there is press involvement, that the Registrar is involved and indeed quite often the Minister?
A. That's right, yes. Yes, and this report obviously was

seen by the Minister or was referred to the Minister.

Q. Yes.

Then in your summing up, at paragraph 3.2.8, you want to point out that the case study illustrates the role of the Registrar in liaising with the inspectors?

A. That's correct, yes.

Q. And because of the media interest that we talked about, that that also involved some Cabinet Secretary involvement?

A. That's right, yes.

Q. The next school then, you look at at paragraph 3.3, is St Mary's Music School in Edinburgh, over the period 2006 and 2010. As you point out in the first paragraph, you give some background to the school, it is both a day and boarding school?

A. Yes.

Q. It gathers pupils in from all over Scotland?

A. And from --

LADY SMITH: International students as well.

A. Abroad as well.

LADY SMITH: And it is a small school.

A. It is a small school, yes.

MR MACAULAY: In the second paragraph, 3.3.2, I think you draw attention to three positive inspection reports over a period of three to four years?

A. Yes, yes.
Q. But then some concerns, I think emerge in relation to sexual behaviour?
A. That's correct, yes.
Q. Can you just take us through the three episodes I think you point to on page 104?
A. Yes, there was a former assistant house parent, but had since left the school, but sang in St Mary's Cathedral choir, was caught with 4,000 indecent images of child abuse on a computer. He plead guilty at Edinburgh Sheriff Court and was sentenced to 18 months' imprisonment. He was then placed on a sex offender's register for 10 years and disqualified from working with children. It appeared that the defendant had been a youth worker at two city churches and had undertaken work at a number of other schools, including Merchiston Castle.

Then a subsequent incident in December 2008, a former teacher at St Mary's was convicted of abusing his position of trust and having a nine-month sexual relationship with a boy. He was again put on the sexual offenders register and he was struck off the General Teaching Council for Scotland's register.
Q. I see the disposal was probation and community service, which on the face of it looks quite a lenient disposal?

A. Yes, but I have no details of what the court proceedings were in terms of the records that were available to me.
Q. The third incident then in August 2009, again we are looking at a house parent, not a teacher?
A. A house parent using lewd, libidinous, indecent practices towards a 15-year-old pupil and having sexual intercourse with another 16-year old, while in a position of trust, was placed on probation.

He again was placed on the sex offenders register, but because he was not a teacher, he could not be referred to the Teaching Council.
Q. If we move on, can we see that the pattern that has now become familiar, namely, because of the nature of the incidents, the Registrar of Independent Schools becomes involved, as indeed does the Cabinet Secretary?
A. That's right, yes. This again was in the press and extremely well reported and clearly the Registrar thought it important to make enquiries.
Q. If we move on, I think you tell us at paragraph 3.3.9 that there was a meeting between the school, the Registrar, the HMIe and also the Care Commission.
A. That's right, yes.
Q. What was the purpose of that?
A. The purpose was to look back at the incidents and assess the issue of the school's knowledge and procedure in

dealing with these particular cases.

The school clarified its position, in the first case the incident did not occur in the school and they were not part of the police investigation, had no knowledge of the alleged crime, the ex house parent convicted, the police had indicated it should remain confidential.

Q. Yes.

A. And as the person was not registered as a teacher, the school was not in a position to inform any professional body.

Q. Did that, as it were, silence on the part of the school cause any difficulty or any concerns?

A. I think there were some legal issues surrounding disclosure of information. And the school felt that they were not in position to disclose matters.

Q. No. Do we learn from what you have discovered that each of the three men had provided the school with excellent references and had been subject to enhanced disclosure checks?

A. That's correct, yes. And if they did not appear on the disclosure checks, there was not an awful lot any employer could do.

Q. Did these episodes then result in the school being asked to prepare a detailed action plan?

A. Yes, clearly the Registrar, HMIe and the then Care

Commission wanted to be assured of its child protection policy and its safeguarding, the procedures that it operated to safeguard the children and young people in its care.

Q. Again, as we have seen before, that seems to be a pattern, that if there is a concern, then the ball is put back in the school's court?

A. Yes, to produce a policy, which can then be reviewed and the documentation that surrounds the issue of disclosure checks on employees, all employees, not just teachers, in terms of the information that they supply and also the procedures within the school to ensure that the pupils are aware of the procedures to operate, if they feel they are in any way threatened.

Q. In the following paragraphs, do you highlight that there was a Care Commission inspection in late May 2010. If we go on to page 108, can we see that that essentially was a positive inspection?

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

Q. Again then, if you look into your overall review, what do you take out of this, this particular example?

A. I think in this case, the Registrar of Independent Schools was central to coordinating a response from the Scottish Government and advising the Cabinet Secretary of the actions being taken and assuring them that

appropriate action was being taken with the school and that the school had instituted upgraded child protection policies.

Q. I think you also identify the collaborative approach taken by the different inspectorates?

A. That's right, yes. Yes.

Q. You then look at Merchiston Castle school. We again have looked at this already in evidence with yourself and it has also formed part of the boarding school case study, so we have some background information about the school. You begin by telling us that the first inspection you draw attention to was a positive one?

A. Yes, that's right, yes.

Q. Do you go on to tell us on page 109 that between 2009 and 2011, two safeguarding issues emerged at the school and can you just take me through these?

A. Yes, of inappropriate behaviour -- the first one related to inappropriate behaviour between a group of pupils on return from a school outing.

The school informed the Scottish Government's Learning Directorate of its response, which was noted but did not result in any HMIe or Care Commission inspection.

The second issue concerned the use and possession of cannabis by some pupils, which resulted in two boys

being withdrawn from the school and two exchange pupils returning to Australia.

There was obviously some testing of other pupils at the school at the time, with agreement of their parents, and advice was provided by the school's medical team.

Q. I think you also identify that there was an allegation by one pupil that five others had been experimenting with drugs, but I think that pupil withdrew that accusation letter?

A. That's right, yes.

Q. As before, do we see that from the perspective of the school, it is asked to prepare an action plan to address safeguarding issues, essentially?

A. Yes.

The HMI noted the school statement and advised the Care Commission that it awaited the decision of the Registrar of Independent School of the action they proposed to take.

The school informed the Registrar of Independent Schools, the HMIe and the Care Commission that it had undertaken an audit of its system of pastoral care and produced a 21-page action plan to develop pupil support, with timescales for implementation.

Q. Do we then have some further inspections and, in the main, with positive results?

A. Yes, that's right. The Care Commission obviously conducted its singleton inspection in June 2010, it made no comment on the school's child safeguarding regime, but later the Care Inspectorate now decided to review the child protection procedures and its first inspection the following year.

Q. Do we see that there is significant input by the inspectorates in these sort of situations --

A. Yes.

Q. -- where there are real concern about safeguarding in particular?

A. Clearly there is a sort of deepening interest in the issue of safeguarding and making sure -- in this particular school, and I think in other schools as well -- that the procedures were up to standard, really.

Q. Again, if we go to paragraph 3.4.5, do you tell us that issues of safeguarding at the school re-emerged in early 2013?

A. That's right, yes, one incident concerned sexual activity between two boys and another an accident out of school. The school promptly reported them to the Learning Directorate and the Care Inspectorate, and the actions of the school were noted by the Learning Directorate, that is Education Scotland basically, yes.

Q. You go on to say that in April 2013, the school also

informed the learning directorate of an allegation that a member of staff had acted inappropriately with pupils in their care during the period 1990 to 1997.

These were historical issues?

A. Yes, these were historical. The school indicated that they had informed the Chairman of Governors and the Registrar of Independent Schools and would seek the advice of the General Teaching Council.

Q. I think this was a current teacher, a current member of staff that was involved?

A. Yes.

Q. Although this doesn't come out from what you have said, I think the documentation relevant to this suggests that the inappropriate behaviour was neither physical nor sexual?

A. That's right, yes. Yes.

Q. But sadly, for whatever reason, after having been suspended, this member of staff was found dead shortly thereafter?

A. At home, yes.

Q. Do we then have another incident where the school informed the Registrar that they had suspended another teacher pending investigation?

A. Concerning historical activities.

Q. Yes. What was the outcome of that?

A. The outcome was, again, Education Scotland, HMIe and the Care Inspectorate were informed by the Learning Directorate within Scottish Government. No action was taken, because the teacher agreed a settlement with the school and returned to the USA.

Q. And no police involvement?

A. There was no police involvement, no.

Q. The Care Inspectorate, as it now became, reported in September 2013 in connection with the school and that the school had prepared an action plan, again, essentially focusing on the lessons to be learned?

A. And the procedures that it would adopt in future.

LADY SMITH: Professor Levitt, do I take it from what you are telling me that you didn't uncover any signs of the Care Inspectorate having adopted a policy of reporting any such matter that could involve criminal activity, that it wouldn't be for them to judge, to the police.

A. I have not come across that, no. But I wouldn't want to have it confirmed.

LADY SMITH: No, no, I was just interested to see, I am not surprised at your answer, given this was still only at 2013.

A. Yes.

LADY SMITH: No indication of anybody in an agency like the Care Commission even thinking about that at that time.

A. I think there are various references in this report to the view that it was the responsibility of the school and the school governors --

MR MACAULAY: Yes.

A. -- rather than the inspection team to take action in such matters.

LADY SMITH: But they didn't actually discuss with the school whether anybody was reporting to the police to let them decide whether they needed to investigate or --

A. There was nothing in the documentation that I came across which suggested that they would seek confirmation from the school on such a point.

LADY SMITH: I am sure you appreciate why I am asking you this, given the current appetite for the possibility of a system of mandatory reporting being introduced.

A. Yes, yes.

LADY SMITH: Thank you.

MR MACAULAY: You identify here that the Care Inspectorate's report of September 2013 was really very positive of the school?

A. Yes.

Q. We then have another blot on the landscape, so to speak, when you draw attention to the fact that, again, it was the school informing the Registrar that it had received a complaint about another teacher after an allegation of

inappropriate conduct when employed at a previous school?

A. Yes.

Q. What was the outcome of this?

A. There was considerable discussion as to the appropriate action that the Learning Directorate, the Registrar of Independent Schools, the Care Inspectorate and Education Scotland, HMIe, to respond to the allegations and the actions undertaken. There was clearly some evidence that there was a cause for concern as to the school's approach to the particular issue.

Q. The complaint of course was in connection with inappropriate behaviour at a previous school --

A. Yes.

Q. -- but do you go on to tell us that the investigation that the school carried out concluded that the teacher concerned had omitted material information at the time of his recruitment?

A. That is right. Obviously in their application, they had not indicated the previous concerns and it would appear that there was nothing in the reference which suggested a concern.

Q. Nevertheless, the teacher had to leave the school?

A. The teacher did not return to the school after the summer break.

Q. No. As you point out this was I think the third incident involving a teacher at the school over a short period and did Education Scotland visit the school in September 2014, I think we are now at -- yes -- to investigate about child protection practices. And the findings were positive?

A. The findings were positive and it is I think important that the Inquiry notes it was a joint Education Scotland and Care Inspectorate inspection.

Q. I think on page 114, you set out some details of the joint inspection, namely at 3.4.11, the team spent three days at the school?

A. Yes.

Q. Clearly a very thorough inspection?

A. Within the pattern of inspections, this is moving on from what I have seen previously to spend three days at a school reviewing the safeguarding policies and the child protection procedures, obviously in some detail, and clearly talking to a whole variety of individuals connected with the school.

Q. Can we see that, again, the Cabinet Secretary is involved in this whole process and that indeed he was advised that a further joint inspection would take place within six months?

A. That's right, yes.

Q. So they are keeping quite a close eye --
A. Clearly there are obviously some concerns which are not necessarily within the written text, that they wanted to be assured that the enhanced child protection procedures and safeguarding policies would be implemented and actually were implemented as a result of a follow-up inspection. A joint follow-up inspection to use the phrase I have used before.
Q. Is the ultimate conclusion, that you come to at paragraph 3.4.14, after a subsequent follow-through inspection by a joint inspection, that the school had made very good progress since the last inspection?
A. That's right, yes. Yes.
Q. It appears the school was doing what it could to deal with the problems that arose, reporting the problems and responding to the action they were being asked to carry out by the inspectorates?
A. And clearly accepting the necessity to improve its internal policies and procedures.
LADY SMITH: There is no doubt that the inspectors did keep up the pressure on the school?
A. I would have thought so, from the text it is clear that they were not entirely happy with the procedures in place and from the text, it is obvious that the joint follow-up inspection indicated that there was some

satisfaction with the school's response.
LADY SMITH: Yes. The school were in no doubt that they were in the spotlight, insofar as the inspectors were concerned, and keeping up the pressure did appear to produce the desired result, so far as what the inspectors were looking for?
A. I read this in the sense that the Inspectorate, that is the Education and the Care Inspectorate threshold of concerns, had moved on and that they were insistent that the school should be aware of the necessity to not take anything for granted.
LADY SMITH: Yes. Yes.
MR MACAULAY: I think, as we have touched upon last week, what comes out of this and the other reports is the extent to which the Minister is involved in the process?
A. Yes. Yes. I mean in this case, again, there was obviously some preference.
Q. The conclusions then, what you draw out of this particular case study at 3.4.15.
A. Yes, there is clearly collaboration between the Care Inspectorate and Education Scotland, the Education Inspectorate, and the working relationship they had with the Learning Directorate, particularly the Registrar of Independent Schools.
Q. Then the next case study you mention is in connection

with Troup House, that you tell us is near Gamrie, this is an example I think of what is required for a new registration?

A. I have deliberately put that in so the Inquiry is aware of the processes and procedures adopted when you have a new registration.

Q. As you point out in the first paragraph on page 136, you set out what requires to be registered with the register when an application is being made?

A. Yes. Yes.

Q. I think there are five points I think. Perhaps you could just identify the points for us?

A. It is quality of education, the pupils' welfare, being safeguarded, the proprietor was a proper person to manage the school, that the teachers were proper people to be teachers and the accommodation and premises were suitable.

Q. Are there two processes of registration, the registration with the Registrar and also with the Care Commission?

A. That's right, yes. Yes.

Q. You tell us what the background to this case was and perhaps we could just focus on that. It is that in May 2005, the proprietors of Troup House submitted an application to register the house as a residential

school which would offer accommodation, education, care and social support for up to 12 children, and you give an age range?

A. Yes.

Q. Would these be children who were experiencing social, emotional and behavioural difficulties?

A. That's right, yes.

Q. It is quite a bespoke and small unit?

A. As in the context of the period an ASN school, Assisted Support Need school.

Q. They then in the rest of the case study set out the processes and the steps involving, for example, an HMIe and CC inspection?

A. Yes, I should also like to bring out I think the last sentence in 3.5.1, that new residential schools require to be approved jointly by the Care Commission and Scottish Ministers.

Q. Okay.

A. Which is part of the sort of story of this particular registration.

Q. It is.

LADY SMITH: That came into place in 2001, did it, requiring joint approval?

A. It did in 2001, yes.

LADY SMITH: Thank you.

MR MACAULAY: Then going on to 3.5.4, you set out deals of the inspections by HMIe and the Care Commission and towards the bottom, is the conclusion that Troup House has all the ingredients to provide very specialised education for vulnerable pupils?

A. That's correct, and I have deliberately included the sort of list here of the checkpoints that HMIe would undertake, safety and security, education, staffing.

Q. Yes. I think the decision at the time was that the education facilities were suitable for 15 pupils, aged 7 to 14?

A. That's right, yes.

Q. At that time, the decision was to approve the application?

A. The decision was to approve the application, on the condition that the proposed number of teaching staff was appointed.

Q. But --

LADY SMITH: There is something wrong with the grammar of that sentence, but I think I've got the gist, which is that you don't get to go forward and open unless we are content that you have enough staff?

A. That's right. The appropriate level of staff and the appropriate qualifications of the staff.

LADY SMITH: Yes.

MR MACAULAY: Yes, because if you are dealing with vulnerable children, then you required qualified staff that can manage the vulnerabilities of these children.

A. That's right, yes. Yes.

Q. But because of planning problems, or delays, the school was not opened at the time it was due to open and the school had to resubmit another application?

A. That's correct, yes.

Q. Did that involve another pre-registration inspection?

A. Yet another to ensure that the building did meet the conditions that had been outlined.

Q. Yes. Was the problem here however that the school jumped the gun to some extent?

A. Yes, it accepted two residential children.

Q. What was the result of that?

A. Clearly this was in contravention of the 2001 Act and that the Care Commission's initial view was to reject the application.

The issue was that the Registrar, it says here, detailed the circumstances surrounding the issue of whether or not to agree the application. I have included this paragraph here, this quote here, 3.5.7, to indicate the process by which a Minister would be informed if there were concerns ahead of a registration and where they would not be:

"Routine decisions are normally taken by officials in the name of Ministers, however where we anticipate that there may be legal challenge or if we think there could be a risk of the consequences leading to criticism of Ministers, we usually refer decisions to Ministers."

So to indicate to the Inquiry the difference between an official taking action because of the belief that there were no issues, to one which would be referred to Ministers.

Q. Yes. Here the issue was the breach of the regulations?

A. That's right, yes.

Q. One of the questions posed by the Minister whether matters had been reported to the Procurator Fiscal and why not?

A. Yes.

Q. What was the answer to that?

A. The Registrar indicated that all outstanding matters had been concluded and the Care Commission has confirmed that we should register Troup House, that is that they will issue a certificate that pupils could be accepted.

Q. Yes. In due course the application was granted?

A. That's right, yes. Yes.

Q. If you look at paragraph 3.5.10, you summarise the position there, I mean you say:

"Although there was a last-minute issue with

granting Troup House's application to register, the case study sets out the protocol adopted by the Registrar of Independent Schools, the Schools Division, the HMIe and the CC when reviewing an application to register a new school."

A. That's right, yes.

Q. That, as you say, was your purpose in setting out this particular case study?

A. That's right, yes.

Q. Can we then move on to the next case study that you looked at, and that is in connection with Geilsland School near Beith, you provide some background to the school on page 121.

As we go on through this particular section, which is quite a detailed section, can we see that serious concerns about the school do emerge. One of the concerns, I think, is that the school had failed to meet requirements that had been imposed upon it by previous inspections.

A. That's correct, yes.

Q. Just the use of language, when one talks about a requirement, is a requirement a matter that might be potentially in breach of a regulation?

A. In breach of either education or the social care legislation, as in the Social Care Act 2001.

Q. Whereas a recommendation is different to that?
A. A recommendation is one seeking an improvement of service which does not necessarily breach the regulation in detail.
Q. If an inspector identifies the need for a requirement, then that, on the face of it looks quite a serious matter, because there is a breach of the --
A. There is a breach which could lead to deregistration.
Q. -- law.

As far as the background to Geilsland is concerned, as you point out, I think here or later, it was -- yes, managed by CrossReach, on behalf of the Church of Scotland?
A. That's right, yes.
Q. The background to aspects of this case is the murder in January 2005 of a young girl by a young boy who had been at some point at Geilsland.
A. That's right, yes.
Q. Was it that that really put Geilsland under the spotlight, at least for the initial investigation?
A. Yes, the initial -- as a result of the report, there were obviously serious concerns about the care provided at Geilsland, a joint HMIe, Social Work Inspection Agency and Care Commission report.
Q. This is another school that offers education, care and

social support to children who were experiencing emotional, social and behavioural difficulties?

A. That's correct, yes. Yes.

Q. You indicate then that there was a joint inspection in November 2005. That involved the HMIe, SWIA and the CC. You set out at 3.6.2 what conclusions were arrived at in the report?

A. It was clearly a report of some concern, because five requirements were to be met by Geilsland within a set timescale and these included dedicated child protection service, a redrafted statement of aims and objectives for the particular unit under question and a review of the security, safety and suitability of its premises.

Q. I think what you set out is that the establishment comprised three separate units?

A. Yes. Yes.

Q. One of the units, Lomond Unit, would appear to have been given a clean bill of health, but it was the other two units that were problematic?

A. That's right, yes.

Q. Do you also go on to tell us at page 122 at 3.6.3, that the requirements from a previous inspection report had not been met?

A. That's right, yes. So there is quite a serious situation here at Geilsland.

Q. How did this then develop, what decisions were taken by the Inspectorate?
A. Well, the issue --
LADY SMITH: Just before you tell us that, I see that the two requirements you refer to were quite different, one review of the aims and objectives, sounds very important, it sounds systemic?
A. Yes.
LADY SMITH: The other may be more detailed, namely security of the premises --
A. That's right, yes.
LADY SMITH: -- as practical and technical, but the first one is really very important on the face of it.
A. But if you put the two together, then there are obviously very serious concerns about whether this particular residential unit should be deregistered or not.
LADY SMITH: And whether that is telling you something about the sense of the responsibility and commitment by those who are managing it, or a lack thereof, perhaps?
A. Or not moving on with the nature of the legislation now in place and the care regime expected of them.
LADY SMITH: Yes, thank you.
MR MACAULAY: Moving on then to see how this developed, as we have seen in previous cases when matters are of

concern, can we see at 3.6.4 that the inspection team informed the Registrar of its draft report?

A. Yes, the issue was whether Scottish Ministers should take immediate action to deregister the school. But there was obviously some concern that, as the Education inspection was not a thorough, detailed inspection, as was usually the case when you are conducting an inspection, there would be issues. That would be certain legal issues concerning moving to deregistration.

Q. Was that a reason that they backed away from deregistration at that point in time?

A. At that point, yes.

Q. You mention in that paragraph the School Education (Ministerial Powers and Independent Schools) (Scotland) Act 2004 and I think in fact what that Act did was to amend the 1980 act?

A. That's right, yes.

Q. I think the sections we are dealing with here -- I think it is amend section 66B to 66D, that sets out the improvement notice process and the rectification notice process?

A. That's right, yes, and brought in also the issue of safeguarding.

Q. Yes.

How did this develop then, because I think we know, as we read on, that an improvement notice was served?

A. That's right. The Care Commission acting on their own issued an improvement notice within the terms of the 2001 Act, which meant that the school could not accept any further admissions until it had implemented the improvement notice.

Q. Yes, and if we read towards the bottom of page 123, the Chief Inspector of SWIA put forward a submission, I think to the Minister:

"The Care Commission is taking enforcement action because the joint inspection identified a significant number of serious shortcomings in the provision of the service, which are likely to have a detrimental effect on the welfare of current and potential service users."

A. That's correct, yes.

Q. It looked very serious?

A. It looked very serious and I think what is interesting is that, in fact, you have the Social Work Inspection Agency also involved in this particular issue.

Q. Do we then have, if we look at 3.6.8, a follow-up inspection involving HMIe, SWIA and the Care Commission, and this was to be in March 2006?

A. That's correct. It is quite a detailed response, really, by the agencies concerned. Clearly indicating

their considerable concern that Geilsland had not acted for some time in meeting the requirements of the legislation in 2001 and the 1995 Act.

Q. You set out on page 125 the findings of the inspection, I think some progress but quite serious remaining concerns?

A. There were clearly some considerable concerns that, although some improvement had been made, further requirements were actually issued to ensure that the quality of care provided was appropriate.

Q. Do we see that three new requirements were set out?

A. Yes, that's right, yes. So you have a situation where you have one set of requirements being met but yet more requirements being imposed.

Q. Do you set out that the Care Commission did accept that Geilsland had made sufficient progress at source to lift the improvement notice and the imposition against new admissions?

A. That's correct, yes. Yes.

Q. We then come to a different process, I think, at 3.6.11. Because here we now have an issue surrounding a notice of complaint by the Registrar. Can you just talk us through this particular process?

A. The issue that the Registrar had accepted that sufficient progress had been made, but believed that new

admissions should not necessarily be accepted. Serious concerns still remain by HMIe about the education provided and the Registrar indicated that the draft report that they had seen did not provide sufficient evidence to act on a number of key issues of concern, that two options were to serve a notice of complaint based on the report or to ask HMIe to carry out a full inspection of all education provision as soon as possible.

Q. And a notice of complaint was in fact served on the school?

A. Yes.

Q. Then if we turn to page 127, at 3.6.13 do you draw attention to a follow-up inspection in mid-July 2006?

A. That's right. This time the Care Commission, assisted by the Social Work Inspection Agency, which I think is quite interesting, undertook a follow-up inspection to assess the progress that had been made.

They were sufficiently satisfied that it varied the condition to permit unit to accept new admissions, although other conditions remained.

Q. Then, following another integrated inspection in November 2006, did the inspectorate remain critical of the school's provision of care and education --

A. Yes.

Q. -- but accepted some progress had been made?
A. Yes, that's right, yes.
Q. It seems to be a long drawn-out process?
A. It is an incredibly long, drawn-out process, involving three separate inspection agencies.
Q. Notwithstanding that Geilsland is making progress, once again we see at 3.6.14 there are new requirements being imposed?
A. Yes. And that an interim integrated inspection will be conducted within a year.
Q. That did happen? You deal with that I think at 3.6.15?
A. That's right, yes.
Q. Did this indicate -- this was a more positive --
A. This was more positive and after final follow-through inspection in November 2008, the HMIe indicated it would not take any further visits in relation to the previous report --
Q. Can we see what CrossReach had done to bring it to this position, it had integrated the service with its sister school in Ballikinrain?
A. Yes.
Q. It effectively had inserted new management?
A. Yes.
Q. And, as a consequence, the staff morale had improved?
A. That's right, and I think it is important to bring out

to the Inquiry the issue of management and leadership within the school.

Q. Yes. Yes.

That is always critical, of course.

A. Yes. Yes.

Q. I think in the penultimate paragraph in this case study, the conclusion from the inspection in November 2008 was there had been good progress?

A. There had been good progress as a result of the inspections and the action been taken by the Care Commission, the Education Inspectorate and the Registrar of Independent Schools.

Q. We come to a point when there has been good progress but the whole process I think began following the murder in January 2005, so it has taken a number of years to get to a point where the progress is such that one could have a positive approach to the school?

A. Well, the final follow-through inspection was published in February 2009, so you are looking at something like four years --

Q. Yes.

A. -- since the initial incident.

Certainly, before that, the previous concerns that the Inspectorate had on Geilsland, so you are looking at perhaps around about six or seven years of concern.

Q. Did you get any insight into why it would take a school like Geilsland so long to get to a point where the care of children was not being put at risk?

A. It is not obvious from the written record, if you like, but it is clear that there were concerns about the management of the school and the staffing of the school, and the issues surrounded ensuring that that moved on, which was the eventual conclusion if you like in 2008/2009.

Q. Yes.

You set out your own conclusions and what you want to draw from this particular case study at 3.6.17, perhaps you can take us through that, Professor?

A. Yes, it was certainly the case that there was a high degree of collaboration between the various inspectorates, Education and Care Commission and, until July 2006, the Social Work Inspection Agency.

Each operating from their particular perspectives, Education, social care and the Social Work Inspection Agency, ensuring continuity relating to the Colyn Evans case.

I think it also indicates that the Registrar of Independent Schools was very closely integrated within the reporting mechanism --

Q. Yes.

A. -- and advised Ministers constantly on the situation at the school.
Q. Right.
A. There was certainly a legal issue about not pre-empting the Care Commission's role and that Scottish Ministers indicated that they were content that further inspections should occur within the specified period of time, as well as other residential units that cater for young people who have displayed sexually harmful behaviour.
Q. The point you make about Scottish Ministers recognising that they should not pre-empt the action of the Care Commission, that highlights the independence that the Care Commission had?
A. That's right, yes.
Q. To such an extent that it could issue the improvement notice?
A. It could issue an improvement notice, but remembering what I said at the beginning, that for this unit to operate, it had to have joint approval.
Q. Yes. Yes.
Then Professor, the next case study is to do with the Royal Blind School in Edinburgh. You give us some background to the school, where it is located, that it provided day education for 34 pupils and residential

care for 79 pupils, so quite a large roll?
A. Quite a large roll, that covered Scottish, English, Irish and some overseas countries as well, placed schools there. This was a directly granted aid school, which I think is important to note.
Q. Clearly children who required significant additional support?
A. That's right, yes. Yes.
Q. You draw attention to an HMIe and Care Commission integrated inspection in September 2005, which, in the main, I think, reading from what you say, was positive?
A. It was positive, but some requirements were actually set.
Q. Let's look at the requirements then.
The first one is -- I think we see this in other cases -- that the school should develop a system to ensure the medical suitability of all its staff?
A. Yes.
Q. Do we see that in other case studies where issues in relation to medication arise?
A. In ASN schools particularly, where there are related medical issues concerning the pupils, it was clearly the case that the HMIe and Care Commission believed that the staff should be appropriately qualified.
Q. Yes. So the staff for a school of this kind, where

children would require medication and indeed were blind or partially blind --

A. Yes.

Q. -- did require to have a particular level of skill in managing these children?

A. That's correct, yes.

Q. You then go on to tell us about a subsequent Care Commission inspection in February 2006, and it would appear that the same requirements were repeated?

A. Yes.

Q. Does that suggest they had not been melt?

A. That indicates that clearly no action had been taken by the school.

Q. Okay, and did the Care Commission receive some reassurance that action would be carried out?

A. Yes. Yes.

Q. I think you draw attention on page 130, towards the top, of there being a complaint made on staff shortage, and that the complaint was made to the Care Commission, did anything come out of that?

A. Well the issue surrounded the Care Commission's role in, if you like, passing on that information to the Learning Directorate, the Registrar of Independent Schools, that as this was a directly granted aid school, it should have been made aware of any particular issues concerning

the education aspects of the school.

Q. Right.

The next integrated inspection with HMIe and the Care Commission you tell us took place in March 2010. Again, looking to what you tell us, that was a positive result?

A. That's right. Except that the nursing arrangements led to a further requirement being set.

Q. That was a requirement that had previously been set?

A. That's right, yes.

Q. There is an incident before the publication of that report, where there is a complaint in connection with the alleged assault of one pupil by another?

A. That's correct, yes.

Q. How did that develop?

A. The complaint was upheld by the Care Commission, indicating that the school had failed to properly assess the behaviour of pupils and meet their supervisory needs, which resulted in a potential risk to the complainer's son.

Q. I think there was some pressure on the Cabinet Secretary through the complainer's MP for some kind of inquiry, I don't think anything came of that?

A. That there was no criminal inquiry, and the issue concerned more the Learning Directorate, effectively the

Education department, being assured that such incidents would be investigated and that the school's policy and safeguarding was enhanced and there were appropriate risk assessment procedures in place.

Q. Okay.

I think you tell us at 3.7.7 that the school inspection reports for September 2010 and 2011 indicated that the requirements had been met?

A. That's right, yes. Yes.

Q. One point you draw out, an interesting point, is that the HMIe, when a complaint is made, has no locus to investigate the complaint?

A. That's right, yes. A particular complaint is not the responsibility, it says, of the inspectors.

Q. But the Care Commission would have a locus, and did have a locus?

A. Yes. Yes.

Q. Can I then take you to your conclusion for this section, at 3.7.12, and what you can draw from what you have investigated.

A. I think several points emerge from this.

First of all, it emphasises the respective inspector roles of the HMIe and the Care Commission. Which, although they were different, were regarded as complementary: educational and care.

It also indicates because of the arm's length nature of the Care Commission, that for a directly grant-aided school, a primary source of information for the Scottish Government on inspections lay with the school itself, that was the school to inform the Scottish Government.

Q. Yes.

A. And that any complaint was essentially a matter for the Care Commission, not the Scottish Government, unless it was deemed an issue for wider enquiry and, as I say here, HMIe had no locus in considering individual complaints.

Q. The point I think you have highlighted and mentioned before is because this is a grant-aided school -- now this is important --

A. This is a grant-aided school.

Q. -- the onus is on the school to report issues?

A. Directly to the Scottish Government. I think it is also important that the last part of that 3.7.12 paragraph, that the role of the HMIe was to review child protection policy and procedures within the school every four years.

Q. The next case study identifies Moore House, Bathgate and you tell us that that was an independent, non-denominational school which provided education and care to young people aged 11 to 16, who were

experiencing social, emotional and behavioural difficulty. Again we have that phrase as to what the nature of the school was?

A. Yes.

Q. I think you tell us it was registered with the Care Commission to provide up to 32 residential places?

A. That's correct, yes.

Q. These children were from all over Scotland?

A. From all over Scotland, yes.

Q. I think the campus operated 24 hours a day for 52 weeks a year?

A. That's right, yes.

Q. Okay.

I think we will see in this case study that, over a period of I think several years, there were a number of inspections, there was disruptive behaviour at the school and indeed in the local community?

A. Yes, yes.

Q. That involved complaints and indeed the police?

A. Yes.

Q. When we come to the end of the section, we see that the school was under a threat of closure but in fact it survived?

A. It survived, yes. Yes.

Q. If we then look at some of the detail, at 3.8.2, you

mention an integrated inspection by HMIe and the Care Commission in November 2004. You say that, although it was recognised the school had strengths in certain areas, "Such as the care and protection of the pupils and the provision of recreation ... but recorded the quality grades of fair in a number of areas"?

A. Yes.

Q. That lowers the strength of the positive nature of the report?

A. That's right, yes, and it is interesting to note what these areas included.

Q. Well, for example, overall quality of obtainment, pupil learning experiences, meeting pupil's needs, expectations of promoting achievement, self evaluation and effectiveness and deployment of staff with additional responsibilities, so these are issues that have been raised?

A. These are issues concerning real quality of education, and the care provided within the school.

Q. As we have seen before, was the plan looking ahead for Moore House to prepare an action plan?

A. Yes, yes.

Q. Which they did?

A. With particular attention on the responsibilities of the Head of Education in this case.

Q. We read on that in the course of -- there was an interim follow-through inspection in January 2006 and although the existence of a restructured senior management team was what is noted, if we read towards the bottom:

"HMIe believed the school was 'Struggling'."

A. That's correct, yes, there were management changes introduced as a result of the previous inspection, but it was still believed that the school was struggling.

Q. If we move on, do we read that Ministers were waiting the follow-through inspection due in January 2007?

A. That's right, yes.

Q. But there was a complaint by a local councillor?

A. Yes, in relation to the behaviour of the pupils within the community.

Q. The Care Commission's singleton inspection in June 2006 reported the issue of pupils' behaviour and you have made the comments you have set out -- perhaps you can take us through these comments because they look quite serious.

A. Right. The concerns regarding the behaviour of management procedures at the school was particularly within the close support units.

That a meeting was held with the school attended by the Care Commission and other agencies to seek to address these issues.

Two placements were withdrawn, terminated.

That one of the close support units would close and be fully refurbished.

Q. I think also there was a high level of absconsions?

A. Yes.

Q. At 3.8.5, you say the issue of pupil behaviour re-emerged in June 2006 --

A. That's right, yes.

Q. -- and escalated. What was the nature of the escalation?

A. The behaviour management at the school raised by the police, the public and members of staff. It would appear to be the same issues concerning behaviour within the school and outwith the school.

Q. Was there a deteriorating picture here?

A. There would appear to be, although the school had ... management had altered/changed, there was still no evidence of the sustained improvement in the quality of provision that the inspectors seemed to require.

Q. Can we read on at 3.8.6 that ahead of a planned inspection, the Care Commission served Moore House with an improvement notice?

A. That's right, yes. Yes.

Q. It would appear that the school, without informing the Care Commission, had transferred pupils from its close

support unit to one of its other houses --
A. That's correct, yes.
Q. -- in excess of the registered --
A. That's right, yes.
Q. -- number.
A. On a technicality, within the 2001 Act, it could legitimately serve an improvement notice as a result of that failure to notify the Care Commission.
Q. But, as we read on, and following up on further inspections, if you look at 3.8.8, where we note there is now a management structure in place?
A. Yes.
Q. Which was understood by all staff. We are having a more positive picture here?
A. Yes. Again, it is an indication that the staff had altered and the management had altered.
Q. As we read on in that quote, that young people were much more settled in the living environments and the high number of young people absconding had reduced significantly?
A. Yes.
Q. There is clearly a degree of positivity here?
A. There is and an acceptance that the school had adjusted its care regime to meet the standards required.
Q. In the following paragraph, following upon

a follow-through inspection in June, I think we have an even more positive picture?

A. Yes, that the school had complied with the enforcement action and that separately the Education inspectors indicated that they believed the school's progress told a good story.

Q. If the story had ended there, then it would have been a good story?

A. It would have been a good story, yes.

Q. Moving on, again we have positive inspections in September 2018 and between September 2009, where the grades were either good or very good?

A. Yes. Yes.

Q. As we read on there, a local resident had previously written to the First Minister making certain allegations. So there is a complaint being made?

A. A complaint being made again of the behaviour of pupils outside the school and within the community. It would appear that Lothian and Borders Police provided information for the Registrar of Independent Schools, who referred the matter to the Education Inspectorate and the Care Commission.

Q. Yes.

The following Care Commission inspection, in August 2010, again, on the face of it, it looks

positive?
A. It does, yes, the quality of environment, the quality of care and support, the quality of the environment, was graded as good or very good.
Q. As against that, an anonymous complaint had been transmitted by North Ayrshire School Work Department, making points about child protection, inadequacy of staffing and prompting the Care Inspectorate or the Care Commission to investigate and take action?
A. Yes. Yes, the now Care Inspectorate in 2011.
Q. Yes. 2011?
A. Yes.
Q. I think there was an unannounced inspection?
A. An unannounced inspection with evidence from the local police, placement authorities, parents and pupils and that four requirements were issued.
Q. These were?
A. A cessation of smoking or preventing its use as a measure of control, checking all agency staff were registered with the SSSC, that the governing board were to provide effective and robust overall management of the service and that there had to be consistency of practice to avoid favouritism within the school.
Q. I think by the time of the next inspection, the first three requirements had been met?

A. Yes. Yes.
Q. Do we have an example here, on the following paragraph, of the Minister actually visiting the school?
A. Yes, it would appear that it was on one of their summer tours.
Q. Yes.

Then at 3.8.13, do you set out that in August 2011, the Care Inspectorate informed Education Scotland that they had received two complaints in regard to the school --

A. That's right, yes.
Q. -- and certain incidents that had involved the police? Can you just summarise what these were about?
A. These were, again, similar issues, concerning the behaviour of pupils and the governance at the school.

The Care Inspectorate, the now Care Inspector attended to conduct a further full inspection and sought whether or not Education Scotland, HMIe as it was, wished to be involved.

Q. Can we see, if we look at the quote on page 140, that the situation has deteriorated quite badly?
A. Yes.
Q. With some 71 separate incidents being recorded by the police since the beginning of June?
A. That's right, yes.

The issues clearly had re-emerged in terms of antisocial activities, certainly outside the school.

Q. Was the result one of the Care Inspectorate deciding to raise legal proceedings?

A. Yes. Yes.

Q. What was the purpose behind that?

A. Before I respond to that, it is 3.8.13 --

Q. Yes.

A. -- the Scottish Government's Head of Care Standards and Sponsorship Branch, it is important I think for the Inquiry to be aware that the --

LADY SMITH: 3.8.13, you said?

A. That's right, yes.

MR MACAULAY: Yes.

A. It is the procedures and policies involved in the way that governments interact with each other and also with external bodies and that the Care Inspectorate were sponsored by the public health wellbeing and city strategies Cabinet Secretary's office. It wasn't within Education, it was within that body and the reasons are historical, because the predecessor body, Care Commission, had really been established in relation to care for the elderly and for mental welfare, as well as children. So the sponsorship branch --

LADY SMITH: Of course.

A. -- for registering lay with this department and not within Education.

So issues concerning protocols within Government rested primarily with this department, who would connect with the Care Commission and Care Inspectorate, and that department would then connect with Education.

MR MACAULAY: I see.

A. I'm sorry if that's is a bit long winded, but it is important for the Inquiry to understand the way that the protocols actually operated.

LADY SMITH: It is entirely understandable, because responsibility for those in care in society goes far wider than just those who are in an educational institution.

A. That's right, yes. Yes.

In this case the Care Inspectorate took appropriate action in terms of the protocol and it was up to that then department, the Care Standards and Sponsorship Branch, to inform Education of the concerns being raised by the Care Inspectorate. A bit long winded, but that is how it operated.

LADY SMITH: Is the general point that all those with responsibilities in relation to the care sector need to be fully aware of which other agencies do or may have an interest?

A. Yes. Yes --

LADY SMITH: Yes.

A. -- and that there is communication between the respective arms of Government.

LADY SMITH: Thank you.

MR MACAULAY: Thank you.

Moving on then, Professor, to ask you about the proceedings that the Care Inspectorate took under section 65 of the 2010 Act. That was for the emergency cancellation of the school?

A. Yes.

Q. On page 140 and the following pages you discuss that.

One point you make, at 3.8.15, is the Care Inspectorate's decision to instigate decisions had been unknown to the directorate and the Care and Justice Division?

A. That is because the previous paragraph indicates that the information had been spent to the Cabinet Secretary responsible for Public Health, Wellbeing and Cities Strategy.

Q. Were they effectively cut out of the equation?

A. Yes, the issue which I have tried to allude to was the passing of information between Government departments.

Q. Yes, okay.

But the action taken by the Care Commission and then

I think they wanted an emergency cancellation?
A. Yes.
Q. It wasn't successful. If we look at page 141 at 3.8.16, the Sheriff at Linlithgow refused an interim order, because of the nature of the test?
A. Yes, that's right, yes.
Q. We see it is a high test?
A. It was a high test. I am sorry, I did have enough information to understand the high test being used, but certainly it came through on the papers that it was a high test.
Q. You set the test out, namely at 7.8.16:
"The Sheriff was not satisfied that unless the order was made, there would be a serious risk to the life, health or wellbeing of persons."
So it is a high test --
A. It is a high test, yes.
Q. -- and clearly not enough was said to satisfy the Sheriff on an interim basis, wasn't it?
A. That's right, yes.
Q. I think there was some further procedural involvement, but in fact the action did not proceed to a conclusion.
A. It did not. I think what I wanted the text to bring out --
LADY SMITH: Professor, I am just thinking about the high

test. It is a difficult one, isn't it, because whilst, if one wants to be really cautious, you would want an immediate cancellation, everybody out, can't take any more risks. But we know from experience, I think if you take, for example, the new school at Butterstone that was very suddenly closed, there was a lot of concern about the harm to children in giving the children so little notice of having to leave the school that they were boarders at.

A. That's right, yes.

LADY SMITH: It is really difficult.

A. A difficult one to judge.

LADY SMITH: It is not the only example I can think of, there have been others in recent years but that was one that immediately came to mind.

Mr MacAulay.

MR MACAULAY: You go on to set out the difficulties, the continuing difficulties, that this school had. But if I take you to page 144, at 3.8.22, following upon an inspection, an HMIe report on the school was completed in mid-November 2011 and indicated that whilst it sustained a positive climate for supporting pupil learning, it held a number of concerns on staff competencies and ability to manage challenging behaviour, and also in relation to staff turnover.

So there are some positive messages there.

A. There are some positive messages there, but I think what the test is trying to establish also is that had Education, had the Learning Support Directorate been informed ahead of the minute going to the Cabinet Secretary for Public Health, then the actions might have been different, in the sense that I think the text is indicating that they could have closed the school on education grounds rather than going through the court.

Q. Yes, there was a mechanism available --

A. There was a mechanism available, but somehow or other that was missed.

Sorry, yes, and the HMI were then sent in.

Q. Yes. If we read on to page 146, at 3.8.6, can we see that now the messages in relation to the school are becoming more positive?

A. Yes. Yes.

Q. In a sense, by overlooking the mechanism that would have effectively ended its existence, we come to a point where survival looks a reasonable prospect?

A. Or quicker action could have been taken to ensure that action had the Education Directorate been involved more quickly.

Q. Well, in that event, if they had been involved more quickly, then would we have reached a more positive

stage earlier than we did?

A. That's right, yes.

I think the text also brings out that in fact the Education Directorate through its social care/social work arm ensured that local social work departments removed their children anyway. So it was a rather convoluted mechanism being used to remove the children from the school.

Q. In the event, if you look at 3.8.27 on page 147, can we see that Scottish Ministers were informed by Education Scotland that the school had met each of the conditions that had been set out previously --

A. Yes.

Q. -- and essentially the school continued to survive?

A. That's right, yes.

Q. What do you draw from this case study?

A. I think, firstly, that clearly the Care Inspectorate and Education Inspectorate, later Education Scotland, could seek to improve the quality of provision, education and care if they worked jointly.

Secondly, it indicated this is a case study which indicates that a service could deteriorate very quickly if weaknesses persisted in management and staff complement, especially when dealing with challenging behaviour.

Again, it indicates that although the Care Commission/Care Inspectorate, HMIe, Education Scotland, inspection processes were different, they were essentially complementary, a twin-track approach --

LADY SMITH: I think that should be complementary with two Es, not an I, is that right?

A. Sorry.

LADY SMITH: Don't worry, I am just checking the sense is as you intended.

A. Yes, sorry.

And that throughout this process, Ministers were kept fully briefed as to the issues at this particular school.

Q. That reflects the pattern that I think we have seen in these cases, particularly where there are concerns over the schools?

A. Yes.

MR MACAULAY: My Lady, I am moving on to look at a separate case study, if we were to rise a bit earlier and come back a bit earlier --

LADY SMITH: That would make sense.

Let's have the mid-morning break just now and then get on to the next case study, which I think is Wellington, after the break.

(11.28 am)

(A short break)

(11.44 am)

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

A. Yes, my Lady.

LADY SMITH: Mr MacAulay.

MR MACAULAY: Yes, my Lady.

We are now moving to look at Wellington School in Penicuik, and you start looking at that case study on page 147, we looked briefly in a previous report at Wellington, but just to remind ourselves, it is managed by Edinburgh City Council and again it is one of the schools that support, accommodate and care and support for children who are experiencing social, emotional and behavioural difficulties.

A. That's right, and is an example from a school that is managed by a Local Authority directly.

Q. Yes, and as we read on we learn that it closed in 2014?

A. That's right, yes.

Q. It accommodated both day and residential pupils, mainly from the Edinburgh and Lothian areas?

A. That's right, yes.

Q. It wasn't a large school, the maximum roll I think was set at 16?

A. Yes.

Q. You draw attention to Care Commission inspections in

May 2005 and 2006, where there was no requirements set for the school?

A. That's correct, yes.

Q. That changed I think in October 2006?

A. Yes.

Q. What was the outcome of that inspection?

A. That was an integrated inspection from Education and the Care Commission itself, indicating that there were concerns regarding the use of the enhanced level Disclosure Scotland checks and that the employer has checked the qualifications of staff.

Q. Yes.

A. And that two satisfactory references were actually required for the employment of staff.

The issues concerned, really, the extent to which Disclosure Scotland checks had been utilised and the qualifications and appropriateness of the staff that the school employed.

Q. Did the Care Commission in a subsequent inspection discover that the requirements had been satisfied?

A. That's correct, that's correct, yes.

Q. Then you go on to tell us that in September 2008 the Care and Justice Division was informed by HMIe that they and the Care Commission had received an anonymous letter making certain allegations?

A. That's right, of a culture of bullying and substance misuse by staff at the school.
Q. Do we see that, as a consequence, four teachers had been suspended?
A. Four teachers had been suspended following the allegations of substance misuse.
Q. Is the message here that the substance misuse was by the teachers rather than by the pupils?
A. That's right, yes. Yes.
Q. Then I think you tell us later on that a teacher was in fact charged with being in possession of illegal drugs?
A. That's right, yes. Yes.
Q. But there was no evidence, you tell us, of pupils being at immediate risk or indeed that they had been involved in drugs?
A. That's correct, from the evidence collected.
Q. Did in any event the Care and Justice Division take the view in the circumstances that it wasn't necessary to alert Ministers?
A. It wasn't necessary, as this was obviously being managed by the Local Authority.
Q. Yes.
At the Care Commission inspection in March 2009, there is no suggestion in that of the existence of bullying or indeed substance misuse?

A. That's correct, yes.
Q. Although we are told, I think there, that smoking appeared to be tolerated?
A. Smoking appeared to be tolerated, rather than substance misuse.
Q. I think we have seen that in other case studies, that smoking seems to be prevalent in many of these schools?
A. Yes. Yes.
Q. And, as you say here, tolerated?
A. Tolerated, yes.
Q. Was the conclusion of this report fairly positive?
A. There was an issue surrounding staff supervision. The extent to which in this particular ASN school the -- if you like the ongoing needs of staff were being supported by the senior management of the school.
Q. Then the following Care Commission inspection that you talk about in the next paragraph, again, I think you say that this is progress, I think, is how one would describe it, is that -- in relation to recruitment for example, medical screening?
A. Yes, the issue surrounded the registration of residential child care workers and that the City Council had overhauled its staff, recruitment and selection process, including pre-employment medical screening to ensure an applicant's physical and mental fitness.

Q. Although there remained concerns, they were not at a level which required notification to Ministers?
A. That's right, yes. Yes.
Q. Then at 3.9.8, in relation to a June 2011 Care Commission inspection, there is a change in the circumstances?
A. Yes, that its management and leadership was recorded as "Weak", which within its language means that certain actions were required.
Q. Yes.
LADY SMITH: I see that quality of care was one of the matters that was particularly recorded as "Weak".
A. Yes. Yes.
MR MACAULAY: You have noted that subsequently, in a December 2012 report, the Care Commission recorded that there had been a significant reduction in the number of residential staff with the City Council closing one of the units?
A. That's correct, yes.
Q. Is this essentially a school that is in decline?
A. It is a school that the educational authority and the City Council have decided that they wish to use alternative provision to meet the needs of these particular pupils and children.
Q. Was it intimated to the Care Commission or the Care

Inspectorate that the Council's position was that it was proposing to cancel the service?

A. That's right, yes.

Q. There is some discussion about that in the next page or so, but if we turn on to page 152, do you tell us at 3.9.10 that the school was closed, because the Minister indicated that they were content not to call in Edinburgh City Council's decision?

A. That's right, yes.

Q. That is something the Minister could have done?

A. They could have done, but it was clear that the alternative new provision was satisfactory.

Q. The new provision, and we may see this in other examples, throughout the Inquiry, that involved the desire to try, if possible, to accommodate children such as these in mainstream schooling?

A. That's right, yes. Yes. Or in day residential schools, in this case, Gorgie Mills or Panmure St Ann's.

Q. The comments you make then at 3.9.11 that you draw out of this case study, could you perhaps just identify these?

A. Yes, I mean initially, in the early part of this period under review, there was no concern by the CCC, but after that date, the joint inspection between Education and the Care Commission indicated considerable concern at

the provision of education in care. Although requirements that had been set had been met, it is evident issues of staff supervision remained.

And that allegations of bullying and drug charge against one of its teachers was certainly recognised, but the follow up was left to the Inspectorates, Education and Care Commission, to deal with, rather than consulting a Minister.

Q. You finally mention that the Council concluded that the alternative provision was more likely to lead to an improvement in pupil attainment?

A. That's right, yes.

Q. The next school you look at is Seafield School in Ardrossan. I think there may have been some mention of that school during the Quarriers case study, in that it was run by Quarriers.

A. That's right. yes.

Q. Indeed owned and managed by Quarriers. As far as its population is concerned, it accommodated 30 boys between the ages of 7 and 17, and again these were children who were experiencing significant social, emotional and behavioural difficulties?

A. That's right, yes.

Q. The children at Seafield, you tell us, were placed by local authorities from across Scotland?

A. Yes.
Q. Again it was all year round residential care?
A. Yes. Yes.
Q. But also provided education for a similar number of day pupils?
A. That's right.
Q. The Care Commission inspection that you identify in February 2006, although some standards of care were good, there were concerns raised which resulted in two requirements.
A. The issue surrounded the child protection policy and also the issue relating to appropriate staffing within the school.
Q. Appropriate staffing in these schools seems to be a perennial problem?
A. Yes, yes, it is not just a question of employing teachers, it is also employing those with a background and qualification in care.
Q. Yes. The reference you make that during the inspection its officers had become aware of some instances of challenging behaviour for young people --
A. Yes.
Q. -- was there any specification given as to what that behaviour consisted of?
A. No, not in detail. But one can have a fair idea that

the staff concerned were having difficulty dealing with it and responding to it appropriately.

Q. Do you tell us that the subsequent inspection in October 2006 found that the requirements that had been set had been met?

A. Yes.

Q. And the following inspection, in March 2007 --

A. Similar, yes, yes.

Q. There had been a period of senior management restructuring --

A. Yes.

Q. -- but there were still vacancies amongst the staff?

A. There were still vacancies in recruiting appropriate staff.

Q. There remained challenging behaviour still amongst some pupils?

A. Yes.

Q. Then, at 3.10.3, do you identify an integrated inspection in October 2007 and that was on the basis of intelligence received before the inspection?

A. Yes, this was a part of a national sample of integrated inspections between Education and the Care Commission. It is not clear whether or not Seafield was chosen because HMIe had received intelligence or the nature of what that intelligence was, but certainly they had

obviously heard issues of concern.
Q. As we discussed last week, one way of triggering an inspection would be, for example, intelligence coming to the ear of the Registrar or HMIe?
A. That's right, yes. Yes.
Q. What then did this integrated inspection find?
A. That the situation at the school had deteriorated, the quality and provision of care deteriorated, that the Managing Inspector, HMIe's Managing Inspector, that is the inspector responsible for managing the process of the inspection, had witnessed a child being threatened with a knife and the police were in attendance and that order had broken down.
Q. Is there also some suggestion of a child being threatened with a knife?
A. That's right, yes, within that quote.
Q. I think also a suggestion that an inspector had also been threatened with a knife?
A. Yes. Yes.
Q. I think you say the Cabinet Minister for Education and Lifelong Learning was informed of these concerns?
LADY SMITH: Do we infer from the way that is written up that the person who was wielding the knife was another child?
A. Yes. Yes.

LADY SMITH: If it had been a member of staff, one would have expected to see that?
A. It would have been a little bit different, yes, the response.
LADY SMITH: Thank you.
MR MACAULAY: Then, at 3.10.5, there is what is described as a pre-inspection visit, I think, on 8 October. You deal with that in that paragraph. It was extended by a day beyond the standard two days --
A. Yes.
Q. -- and that some of the evidence raised significant concerns?
A. That's right, yes. There was clearly evidence of Local Authorities removing pupils because of welfare issues and a parent had alleged four assaults on their son, two of which had led to hospital treatment.
Q. As we read on, do we see that two day pupils were suspended?
A. That's right, yes.
Q. Reading on, do we then see that the school was at risk of becoming objectionable, which is a term used in the Act?
LADY SMITH: We are now at 2007, are we?
A. 2007, yes.
LADY SMITH: Thank you.

MR MACAULAY: Do we see then that the Registrar has recommended the imposition of certain conditions, at 3.10.6?

A. Yes.

Q. Can you just develop that for me. This is coming directly from the Registrar?

A. This is coming direct from the Registrar.

The inspection team indicated the willingness of the school to engage rather than removing it from the register of independent schools, imposing disqualification on staff and the manager and serving a complaint. The Registrar recommended three conditions, concerning the school's behaviour policy, improvements to the curriculum and an increase to the length of the teaching week.

Q. As we can see, there are real concerns about what is happening at the school but, nevertheless, the policy is to seek to engage with the school?

A. That's right, as long as the school was willing to accept that engagement.

Q. Then, if we look at 3.10.7, here we have an HMIe and Care Commission report published in March 2008 --

A. Yes.

Q. -- six months after the inspection. Can we see that there are serious concerns about what is happening at

the school?

A. Yes. The use of physical constraint, there is clearly a behavioural issue amongst the pupils themselves, in terms of consideration for others, use of violent behaviour, which required adult intervention and this impacted on the teaching and learning across the school.

Q. I think you go on to say that staff morale overall was low?

A. Yes. Yes. Because of staff absence, amongst other issues.

Q. As we have seen before, the school and Quarriers executive were asked to prepare an action plan addressing the report's main findings?

A. Yes, and that a follow-up inspection would occur.

Q. Do we see that between February and May 2008 HMIe and the Care Commission visited the school on three occasions?

A. Yes.

Q. What were the results of these visits?

A. After the third visit, the HMI felt confident enough to recommend the removal of the conditions set, that physical restraint was rarely now in use and that there was no sense of disorder.

Q. As we read on, do we see, on page 157 -- just about halfway down the page, about -- in connection with

a follow-through inspection in January 2010, that the service had made significant progress?

A. Yes.

Q. So this is a positive message, it was --

A. It was a positive message, which resulted in -- if you like, that there would be no further visits in relation to the initial joint inspection report.

Q. As we read on, do we see that in 2012, Education Scotland and the Care Inspectorate received two complaints --

A. Yes.

Q. -- and carried out an integrated inspection?

A. Yes.

Q. What were the results of that inspection?

A. There had been a sort of a reduction in the number of pupils, both day and residential, as a result of the Local Authorities taking a strategic decision that looked-after children should remain in their own areas, and the school was therefore reviewing its purposes.

Q. Yes.

At 3.10.12, looking at three quality indicators, I think the scores were weak, satisfactory and good?

A. Yes.

Q. But one requirement was set out, which I think we have seen something similar in the past, in relation to

medication. What was that?

A. The issue was the use of controlled medication or rather its management of controlled medication and that the procedures used should follow the guidance by the Royal Pharmaceutical Society.

Q. As we read on, at 3.10.13, do we see that under reference to the traffic light system, that the school was designated as amber, and if I --

A. Yes.

Q. -- look at my notes, amber, "Write noting positive points but expressed concern over the areas for action in report, asking for progress report after X months".

A. That's right, yes.

It is basically indicating that a further follow-through inspection or integrated inspection or interim inspection, however it was termed, would occur.

Q. As we read on, on to the next page, page 159, do we see there that a number of requirements have been set out by the Care Inspectorate at paragraphs 3.10.14?

A. Yes. I think it is important to recognise also that the Registrar of Independent Schools noted the report, but that the amber finding was actually quite serious, indicating that perhaps it was slightly more towards the red side, red light, rather than just amber.

Sorry, yes.

Q. That is fine.
A. The Care Inspectorate listed a further requirement --
Q. It is quite a detailed requirement.
A. It is extremely detailed, yes.
Q. There are a number of limbs to it.
A. Yes.
Q. Do we read on that the following Care Inspectorate report in February 2013 did indicate that that detailed requirement had been met?
A. Yes.
Q. And there was a much more positive --
A. Yes. Yes.
Q. I think there was a suggestion thereafter that the managers wanted to vary its registration and admit girls to the school?
A. That's right, yes.
Q. Did that happen?
A. Well, ahead of that further integrated inspection by Education Scotland and the Care Inspectorate indicated three requirements.
Q. You set these out.
A. Yes, I set these out.
In the process of discussion, Quarriers decided to close the school.
Q. Again, just looking at the requirements, item 3 on

page 160, again the focus is on medicine management?
A. Yes. Yes.
Q. Although I think the Education Scotland/Care Inspectorate inspection which took place in October 2013 indicated that the requirements had been met, as you had pointed out, Quarriers decided to close the school?
A. That's right, yes. Yes.
Q. What do you take from this case study then, Professor?
A. I think the first point is, again, following past examples, the Inspectorate preferred to work with providers. If they assessed that the provider was willing and could implement the statutory requirements and in this case that issue was endorsed by the Cabinet Secretary for Education and Lifelong Learning.

Again, the inspectors worked closely with the Registrar of Independent Schools. As a result of the inspection, if there were issues, the Registrar would take the lead in advising Scottish Ministers of possible enforcement action.

I think also, reading this one, it indicates again that there was considerably greater depth in the assessment of both the quality of education and the care provided. Again, you would see follow-through inspections where wider issues actually emerged.
Q. Can we note in passing at 3.10.20 that, at least

a significant reason for the closure of the school was the lack of referrals from local authorities?

A. Yes.

Q. Which meant that the school would run up a large deficit?

A. That's right, yes.

Q. I think we are seeing here the change in trend, with local authorities placing children in different types of establishment?

A. That's right, yes.

LADY SMITH: Professor Levitt, do we see from this case study, and indeed some of the others where the Inspectorate homed in and focused on an institution that required checking and checking again and supervising checking again --

A. Yes.

LADY SMITH: -- that it has implications for the resourcing of the Inspectorate?

What I have in mind is that the Inspectorate seems to need to have the flexibility to produce enough inspectors and enough inspections when required, whilst still carrying out its routine work?

A. Yes, I did seek to try and address that particular issue about the staffing of the ASN Inspectorate, and there is some evidence that they were fully taxed in terms of

their ability to conduct inspections, but towards the end of this timescale, there were rejections on public expenditure and that reduced the number of inspectors available, and there are odd complaints -- which I am sure I could dig out if required -- that we don't have the staff necessary to continue with the inspection regime we have at present.

LADY SMITH: It seems there is an obvious risk of that --

A. Yes, there is, yes.

LADY SMITH: -- because I suppose even if you run the Inspectorate, as I think has been done, on the basis that you have people you can call on to be involved in inspections, who will be paid a fee per inspection or whatever --

A. All right.

LADY SMITH: -- you still have to have the funding to pay them, they may not be full-time employees but they need to be paid for what they are doing.

A. They need to be paid for what they are doing, but the policy, certainly post-2010, was to undertake risk assessment and then base inspections on that risk -- if you remember the section I had on the scrutiny issue, and so you can see that, obviously, in this case, Seafield, there were ongoing concerns, which presumably resulted in staff being released to conduct the

follow-through inspections.

LADY SMITH: Yes. Yes.

One might say, well, there is an example of this close work by the inspectorate working, because working with the management of Quarriers they reached the stage that the right answer was reached, which was that they had come to the end of the line?

A. That's right, yes.

LADY SMITH: But that may have had implications for their ability to do other work and lengthen the time period between routine inspections elsewhere?

A. That is right, yes.

You should also remember that in this period there were Link Inspectors, and that Link Inspectors would remain in constant contact with schools and the evidence suggests in this case that there was constant contact between the Link Inspector and the school in between inspections.

LADY SMITH: Yes. Thank you. I am sorry I have digressed, but it seemed important to pick that up just there.

Mr MacAulay.

MR MACAULAY: My Lady.

The next school you revisit, because we have looked at Donaldson's School before, and that is Donaldson's School, I think by now, if not before, it is now located

in Linlithgow. We did look at Donaldson's last week for the previous period that you were covering in these reports. On the face of it, there was a litany of different problems with the school at that time?

A. At that time there was, yes.

Q. Including the school being the only school in Edinburgh, as I think you mentioned, where children had not received the city's full child protection programme?

A. That is right, yes.

Q. This was down to the Headmaster, I think, who was reluctant to engage?

A. That's right, yes.

Q. And, in particular, reluctant to cooperate with the Local Authority registration scheme?

A. That's correct, yes.

Q. We will remember I think the allegations about the Headmaster being very drunk and on one occasion entering a female student's room and falling asleep in the bed?

A. That's right, yes.

Q. The other point I think that came out last week is just how much the governors were out of touch with the school?

A. Yes. Yes, they were unaware of what was actually happening within the school.

Q. Although it was their duty as managers to register the

school?

A. That's correct, yes.

Q. I think some further problems then re-emerge, do they not, in this period that you are looking at, 2009 to 2014?

A. Yes.

Q. If we begin at 3.11.1, you draw attention to an inspection in August 2009, an integrated inspection, which produced a very positive result?

A. Yes. Good, very good or excellent.

Q. Yes.

Then the subsequent Care Commission and Care Inspectorate, the singleton inspections in 2010 and 2011, rated the school as good or very good, but the inspection in 2012 graded certain aspects of its quality of care and support as weak. That caused the imposition of three requirements.

A. If I could bring out of course that the inspection in February 2012 was part of the six monthly cycle of inspections.

Q. Yes.

A. Yes.

That the staffing was an issue and that they were required to ensure there were enough suitably skilled and competent staff on duty to meet the needs of the

children and young people.

Q. Again, we see this point arising time and time again, in relation to children who are vulnerable?

A. In this case, that the staff who were competent in British Sign Language.

Q. Yes.

The second requirement you told us about on page 163, is that again to do with the management of medicines?

A. That's right, yes, the recording of the administration of all medicines should be safe and effective and it also included non-prescribed medication.

Q. Yes, and the final requirement was to do with quality assurance systems?

A. Yes. The provider, which of course means the governors, not just the headteachers and principal, should assure themselves of the quality of the service being provided and that would include internal audit procedures to identify any deficiencies in the quality of service and that the governors, right, and registered manager of the service must have an effective overview of the service provided.

Q. Do we see then that in the subsequent Care Commission inspection in June 2012, that the requirements had been met?

A. Yes. Yes.
Q. And a change in management?
A. That's right.
Q. And, indeed, the introduction of new work patterns and staffing systems and here we have a positive outcome?
A. A positive outcome, which again led in January 2013 to grades of good or very good across the quality themes.
Q. Although I think in that same report, if you go to page 164 at 3.11.5, there is a suggestion that there was some reference to tensions within the staff group about senior managers?
A. Yes, that was the next integrated inspection, sorry, which was conducted in 2013.
Q. You are quite right, May 2013.
A. Yes, yes. From memory, I think there had been an earlier integrated inspection in 2008/2009, so this was within the four-year cycle of integrated inspections.
Q. Okay.

You tell us at 3.11.16, that shortly before the reports --

LADY SMITH: I think that is 3.11.6, is it?
MR MACAULAY: I'm sorry, yes, 3.11.6, on 164, that there was a press report in connection with an investigation.

Can you just develop that for me?

A. Yes, inappropriate behaviour by a member of staff, made four years ago, had been dealt with at the time, that is at the establishment of the school at Linlithgow, 2009 then, inappropriate physical act by a member of staff which involved a youth who was not connected with the school. Ie that referred to an incident outside the school concerning that member of staff.

Q. Do we see that, because of the report and the lack of action at the time, both the chief executive and the head teacher had been suspended?

A. That's right, yes.

Q. That the member of staff who had been a support worker was later convicted at Falkirk Sheriff Court of indecent assault?

A. And placed on the sex offenders register.

Q. Following upon that, did the Edinburgh ES and the Care Inspectorate agree to extend the integrated inspection?

A. Yes.

Q. And produced a report covering the period August to October 2013, what were the conclusions of that report?

A. I think the issue there is it related to the governance and communication between the board, the school and the parent. That is the extent to which the board were fully aware, which reflects the earlier comments being made about the extent to which the board of governors

were actually in effective charge of the school.

Q. You say the earlier comments, you are going back to the previous report?

A. Yes. That's right, yes.

The report indicated that there were weaknesses in governance of the school and communication between the board, the school and stakeholders:

"The board members do not have a shared understanding of their governance role. The lack of effective mechanisms for holding the school to account and the quality of education and care it provided ..."

Q. Yes.

A. "... had not been involved in school procedures for dealing with complaints from staff or parents with child protection and safeguarding issues. It was the ultimate responsibility of the Principal to ensure that that took place."

Q. What was required to improve matters?

A. Yes, that the school needed additional support and time to make the necessary improvements and that the Inspectorate, that is HMIe and the Care Inspectorate, would continue to work with the school and the board of governors to build capacity for improvement.

Q. Do you tell us, moving on from there, that the HMIe and Care Inspectorate follow-through inspection was in

May 2014 and commented that since the previous report, good progress had been made in almost all of the main points?

A. That's correct, yes, but that further action needed to be taken to embed the improvements within practice.

Q. One issue was the lack of stability in relation to senior management posts and also the high levels of staff absence that required to be addressed?

A. Yes, a combination of issues dealing with senior management and staff absence.

Q. Then, at paragraph 3.11.10, on 6 November 2014, the learning directorate was informed by the Donaldson's Principal of the suspension of the Acting Headteacher following serious incidents and concerns.

Can you just develop that for me, what was being conveyed here?

A. In that paragraph section what I have tried to do is to indicate the -- if you like the timeline of involvement, really looking at the serious nature of what appeared to have transpired and the response of officials and Ministers to the issues that were being raised. So in fact you start off, Thursday, 6 November, that Ministers, Education Scotland, Care Inspectorate notified immediately, and that officials then the following day held discussions, that a member of the

Learning Directorate, that is an official from the Scottish Government, went to the school and to ensure also that the safety of the pupils over the weekend was guaranteed.

On Monday, 10th, inspection activities continued through the week:

"The concerns raised during the inspection, in detail, ranged from allegations of sexual and physical assault by pupils on pupils, to a culture of bullying, a lack of leadership control and ineffective systems and processes."

Q. Do you go on to tell us that the Cabinet Secretary was informed of the situation?

A. Yes, was informed of the school's situation on the 14th, with a detailed submission.

Q. Did the acting headteacher remain suspended pending a disciplinary investigation?

A. That's right, yes. Yes.

Q. The school was described as remaining fragile, is that how --

A. Yes, yes, there was obviously considerable concern regarding the operation of the school.

Q. Again, we note that the high levels of staff absence, that tends to suggest a lack of morale?

A. Yes. Yes. A breakdown within the school itself.

Q. Yes.

The submission that is being made to the Cabinet Secretary goes on to say:

"Allegations that proper safeguarding and recordkeeping procedures were not followed in relation to a number of alleged incidents at the school, including allegations of sexual and physical assault."

A. Yes.

Q. Moving on the acting headteacher "... did not take steps to close one of the classrooms following an investigation by the Health and Safety Executive ... found some of the machines in the room were unsafe ..."

There were serious failures being identified?

A. Quite serious failures, yes.

Q. As we have seen before, then, was the way ahead as described in the next paragraph, 3.11.12, the preparation of a robust plan?

A. Yes. Yes.

Q. Did this develop into a situation whereby permission was sought from the Cabinet Secretary for the immediate use of a preliminary notice?

A. Yes. Yes.

Q. Did that happen, if you look at 3.11.14?

A. 3.11.14, it was taken in person by an official to the school that day.

I think what I wanted to get across here, how quickly and promptly action was taken in regard, once the provisional draft, if you like, report from the Inspectorate was received within Government.

Q. If we move on to page 169, at 3.11.15, can we see here, in the quotation, that Education Scotland and the Care Inspectorate, having considered the response from the school, had advised that they had limited confidence that the school could make the improvements required in the preliminary notice?

A. That's right, yes.

Q. But, as before, do we see that the plan was to continue to engage with the school?

A. On a voluntary basis.

Q. Yes.

A. I think to ensure that the action plan being developed was actually implemented.

Q. I suppose we may have discussed this -- I think we did discuss this last week, it would be difficult to take more draconian action with a school such as Donaldson's --

A. I think I indicate that earlier on, that the issue was alternative -- in 3.11.12, it would be difficult to find alternative placements under short notice, and therefore the Education Inspectorate, Care Inspectorate and for

that matter the Scottish Government are in some difficulty with the needs of these children, as they were.

Q. Really they were between a rock and a hard place, in a sense?

A. Yes. Yes.

Q. The inspection I think report after the preliminary notice was served, you set out at 3.11.16. I think there is a focus on trying to improve the behaviour of children and the deployment of staff, involving parents in fact?

A. Involving parents as well.

Q. At 3.11.18, again, do we see even at ministerial level, indeed at ministerial level, that the policy was to continue to engage with the school to see if improvements could be made?

A. Yes, but that would include the employment of a high-quality headteacher and new board members. If you like, that was the qualification attached to the voluntary engagement with the school.

Q. If you look towards the end of this process, then, taking it shortly, at 3.11.19, can we see that the follow-through Education Scotland and Care Inspectorate inspection published in September 2015 indicated the progress made since the previous report in

December 2014 --

A. Yes.

Q. -- and that there was a change of board membership, which gave the school a much better mix of skills to provide appropriate support and meet challenges?

A. That's right. At the end of the period under review, clearly that enough had been said to recruit board members with more requisite skills.

Q. It required quite a transformation of personnel?

A. Yes. Yes. A complete change of personnel.

Q. What you draw from the case study you set out at 3.11.20, perhaps you can look at that and take me through that?

A. Yes, I mean, again, it indicates the desire of the Inspectorates, Education and Care, to work with the provider, if the provider was willing and could implement the regulatory requirements. But in this case, it was evident, certainly towards the end of this period under review, that the management of the school, found it difficult to implement the required changes with these pupils with complex additional support needs.

Thirdly, that there was clearly ministerial involvement at a very high level. And in this case to agree to preliminary notice under the Education (Scotland) Act 1980, and, again, I think bringing out

what I said at an earlier one, it indicates the considerable depth in the assessment of the education and care that the Inspectorate were seeking to address.

Q. Certainly in both cases for Donaldson's that we have looked at, on the face of it, it did involve significant engagement by the Inspectorate --

A. That's right, yes.

Q. -- to bring about a position where the schools could survive?

A. Yes, and again referring to an earlier position that the Inspectorate went in immediately in November.

Q. Yes, but it was a protracted process?

A. It was a protracted process, involving a considerable number of the Inspectorate.

Q. Yes.

The next school you look at is the New Struan School in Alloa, I don't think we have looked at this school before. What you tell us there is that this was an independent residential school and offered care and education to children and young people with autism --

A. Yes.

Q. -- and it was managed by the charity Scottish Autism.

I think it had both day and residential pupils; is that correct?

A. Yes, yes.

Q. From across Scotland?
A. Yes.
Q. Day for pupils from about 15 and residential for about 16 pupils, so about 50-50, basically?
A. Yes.
Q. An inspection that you make mention of in that first paragraph at 3.12.1, was published in October 2014, but I don't think any issues arose out of that inspection, is that --
A. No.
Q. No.

Then we come to paragraph 3.12.2. We note that there has been an anonymous complaint to an MSP, which had been forwarded to the Scottish Government.

Can you just tell me about that. What was the complaint about? It may help if you look at the next paragraph, 3.12.3, where I think --

A. Yes, sure, yes.

There were issues concerning the staffing of the school, turnover of staff, allegations of standards not being met, use of inexperienced and unsupported staff as well. An indication that the school was undergoing a process of restructuring, as a result of the changing profile of children that the school was accepting. There was certainly a recognition by the management that

there was a requirement to change the staff contracts and restructure the school in relation to providing 52-week cover.

Q. I think the Ministers became involved and the planned integrated inspection that was to take place in October, in fact was taken forward to September 2014?

A. That's right, yes.

Q. What was the outcome of the inspection? That is at 3.12.5, I think.

A. Education Scotland informed the Division, the Education Division looking after this area, that the restructuring decision had been well managed and the staff appeared happier. Although Education Scotland did not have any concerns about the safety any wellbeing of the pupils, it was really a matter for the Care Inspectorate. The Care Inspectorate promptly responded and stated that the school had met the two requirements.

Q. In the report itself, you talk about at 3.12.6, do you set out that the grades were low?

A. The grades were low, with evaluation of the curriculum was weak.

Q. Were two requirements set?

A. Two requirements were set.

Again, the issue concerning medication, written consent from children's parent or guardian for all

medication administered by staff, ensuring the staff record instructions for administering medication, children's folders to reflect those on the prescription or label, to ensure that staff only used the approved version of the medication, administration record chart, that the previous policy concerning medication should be removed, and other risks concerning the medication applied.

Q. That first requirement, it is -- as you say -- to do with medication, but it is a very detailed --

A. It is very detailed, yes.

Q. It is very detailed guidance?

A. That's right, yes, it shows again the extent to which the inspections were becoming more in depth.

Q. Yes.

The second requirement was to the effect that the provider must provide staff with regular opportunities for planned supervision in line with the services policy?

A. That's right, yes, that in fact the staff should -- the staff should be seen to be -- should be seen in action as part of the supervisory policies and activities of the senior management.

Q. Yes.

Then, we see again, I think, that the Inspectorate

is prepared to allow the provider time to make the necessary improvements?

A. Yes. Yes.

Q. Do you tell us then that thereafter there was a follow-through inspection in February 2016, it is beyond the timeframe you are looking at --

A. Yes.

Q. -- but I think you nevertheless tell us that the school had made important improvements?

A. Yes.

LADY SMITH: Professor Levitt, you included a quotation there regarding concerns about the covert administration of medication. Could you work out what had been going on?

A. I am not sure. Clearly that was outside, if you like, the scheme of approved medication and it might well have been that children and pupils were given medication outside the timeframe. If they were required to be giving two sets of pills at a particular time, and then later at another time, it was not necessarily -- say the medication was being applied at 8.00 am and then it was supposed to be 6.00 pm, perhaps it was being applied in the middle of the day.

LADY SMITH: Do you think it might also have related to something we saw in another institution of perhaps the

prescribed brand not being used but a different brand being used?

A. Yes, it may well have been. There is not enough detail in this to actually understand what they meant by "covert".

LADY SMITH: It is quite a strong word.

A. It is an extremely strong word, which indicates a serious concern.

LADY SMITH: Thank you.

MR MACAULAY: We can perhaps have a look at the report itself to see whether any more --

LADY SMITH: We could do that.

MR MACAULAY: -- insight do can be provided for that.

Then if we look at the final paragraph in this section, 3.12.9, can you pull together what you have taken from this particular case study?

A. Yes, again, that the singleton and joint inspections indicate that care and education required the specific attention of the service provider.

Clearly it indicates again that Scottish Ministers became involved, that the school should continue to meet the school's needs, and if by necessary by restructuring exercise. Accepted that an integrated inspection should occur ahead of schedule.

Q. Okay.

A. To re-emphasise the point I am making again, I think with that particular quote on 3.12.6, considerable detail in relation to medication.

Q. Yes.

Medication, as we have seen, is a topic that has arisen quite regularly, particularly in relation to the schools where you have vulnerable children --

A. That's right, yes.

Q. -- with special needs?

A. Yes. Yes.

Q. Then, you provide us with a short review of this particular chapter or section dealing with residential schools. Can you take me through that fairly quickly?

A. Right, there were three significant developments in residential school inspections.

HMIe and the Care Commission had formalised the nature of integrated inspections to ensure an integrated overview of the quality of care and education.

Follow-through inspections could occur, and, as we have seen, could occur at less than the 12-month intervals if required, where issues emerged.

In issues of heightened concern, the flow of information ensured that Scottish Ministers were kept informed of events, and directions sought by officials on future action where that was deemed necessary.

There was clearly a memorandum of understanding between the Care Commission and the Scottish Government, and although it is evident that the Care Commission should operate at arm's length, it would seek to inform the Scottish Government if an improvement notice was to be issued or a registration cancelled.

There was an expectation that the Registrar and Care Commission would share information to ensure the safety of the pupils, seeking to maintain the integrity of the regulatory process.

It is evident in the cases presented here that the Registrar, Care Commission, Care Inspectorate worked collaboratively, as you can see, that reference to Castle -- Moore House and Donaldson's -- sorry, that should not be St Mary's Kenmure, it should be Geilsland, sorry.

LADY SMITH: Yes.

MR MACAULAY: Yes.

A. Again, quite often ministerial instructions and directions were sought. The Education Act 2004 indicates, from the evidence here, that the Registrar of Independent Schools' role in advising Scottish Ministers was enhanced. And that the reports from Education and the Care Commission formed a central focus for the Registrar ahead of any recommendations of Scottish

Ministers, as can be seen at Geilsland, Seafield and Merchiston Castle.

There was certainly a new era here in inspection and I think I have indicated a kind of deepening of the way that inspections were conducted and the information sought.

Q. Yes.

A. Finally, I think we have stressed this before, if managers of a school were prepared to engage in the improvements, then that was acceptable. So long as the standards were met after a period of time.

Q. Thank you for that.

Then we come on to the next chapter, which we can begin at page 177, and that is to do with secure accommodation.

In relation to the introductory section, before you look at the case studies, I think it is fair to say we have already covered much of this material?

A. Yes.

Q. Including, for example, the assumption by the Care Commission of the Inspectorate for Secure Accommodation, assisted for a period by the SWSI. I think you also mention again the memorandum of understanding that you have just mentioned a moment ago. I think we have also already looked at the background to the expansion of

secure care.

If I can begin by -- I think I can actually go straight to the case studies themselves, unless there is a particular point you feel I should draw out from the introductory section?

A. Right, it is the methodology used --

Q. I meant to ask you about that, could I ask you about that --

A. -- in drawing out the case studies.

There were two related issues.

Firstly, is the extent to which weaknesses were recorded within the published reports upon the Care Inspectorate, Care Commission, HMIe and Education Scotland.

The second was the extent to which, if you like, the Scottish Government documents indicated ministerial concern, right, now, that means there is not an awful lot after 2010. I think it is important to realise that there was a publication by the Care Inspectorate 2015 which dealt with the period 2011 to 2014 on its work.

There is a section on that in secure services, which indicate that secure services were rated throughout that period as either good or excellent, and therefore it indicated that there had been an improvement in the quality of services being provided within secure

accommodation, which explains why there is not an awful lot of material within the Scottish Government files on issues concerning the secure accommodation after the period 2010/2011.

Q. Sorry, if there is a particular provider that we might be interested in, that we know about, in connection with whom there may have been more recent reports?

A. That's right, yes.

Q. Then you would not have had access to that material?

A. I would not have had access to that material, because it would appear that nothing was coming from the Care Inspectorate, Education Scotland, of concern. I can give you the page reference on that report, which is page 41 of the triennial report from the Care Inspectorate, which indicates that it sees improvement within the secure services.

Q. Yes, although I think we know separately that there have been concerns about at least one provider more recently.

A. I did also look at the published reports from the Care Inspectorate and, yes, there is not a lot of evidence of concern within the grades that they actually awarded and the reports I read in that particular period. So hence there is very little after 2010/2011.

Q. Yes.

One of the providers that we might be looking at in

the course of the list, what we call the List D case study is Edinburgh Social Services, ESS?

A. Yes.

Q. Who used to be I think at Howdenhall and St Katharine's?

A. That's right, yes.

Q. I think we heard that relatively recently there had been some criticisms of these establishments, so if there were to be a Care Inspectorate report of ESS, would that be something you would not have access to or --

A. I did have a look at the published reports from the Care Inspectorate, Care Commission, Education Scotland and the previous Inspectorate and there is a joint inspection I think in 2005, and another one I think in 2011/2011. The 2010/2011 does not indicate any issues of concern.

Q. Right.

A. The 2015 joint inspection, between Education Scotland and the Care Inspectorate, indicate concerns. But that is outside the timeframe of my report.

Q. I see.

A. So I can't report on something that ...

Q. I see. Thank you for that. I am obliged to you for raising that.

Perhaps one or two paragraphs I can take from the introductory section before I look at the case studies.

4.1.3, I take this just to highlight the differences in terminology, if nothing else, that might be brought about by changes in administration. You tell us there for example that in 2005 the Minister who covered the care and education aspects of secure accommodation was the Minister for Education and Young People, but following the change in administration in 2007, the post was held by the Minister for Children and Early Years?

A. Yes.

Q. That is a change at least in terminology?

A. It is a change in terminology.

Q. Is it a change in jurisdiction, and by that I mean --

A. Not really.

Q. Not really?

LADY SMITH: A change in the level of seniority amongst Ministers?

A. No, that was if you like a Junior Minister reporting to the Cabinet Minister, the Cabinet Secretary for Education and Lifelong Learning. So it was a Junior Minister within that department who held that portfolio on a day-to-day basis, reporting to the Senior Minister, the Cabinet Secretary.

LADY SMITH: I see that, but before the Senior Minister was Education and Lifelong Learning Minister, are you telling us that there was only the Minister for

Education and Young People charged with these responsibilities? Do you see what I mean?

A. No --

LADY SMITH: You start by telling us in 2005 care and education in secure accommodation was covered by the Minister for Education and Young People.

A. That is right. It is just my writing and I have made some assumption -- there were two junior ministerial posts throughout that period reporting to a Senior Minister.

LADY SMITH: From 2005?

A. Yes, yes.

LADY SMITH: Thank you.

MR MACAULAY: After the change in administration, 2007, the post was held by the Minister for Children and Early Years and that is a junior ministerial position --

A. That's right, yes.

Q. -- within the brief held by the Cabinet Secretary for Education and Lifelong Learning.

You go on to say, "As in other areas concerning looked-after children, Ministers held responsibility for the SWIA and the HMIe, and those ministerial portfolios also covered oversight of the work of the Care Commission and, from 2011, the Care Inspectorate".

A. Yes.

Q. And also Education Scotland?
A. As far as it concerned children.
Q. Indeed, indeed. The latter incorporating HMIe.
We see the changes, particularly the CC becoming the CI, HMIe becoming the ES?
A. Yes.
Q. The CC was of course an independent organisation, as was the Care Inspectorate, but of course it was also a separate corporate body?
A. That's right, yes.
Q. And the HMIe as against the ES?
A. HMIe was a Government agency, as was Education Scotland.
Q. Yes. I mean is that more than a change of name, by that I mean is there a change in jurisdiction?
A. There is no change of jurisdiction in terms of the inspection regime of secure accommodation.
Q. Okay.
Just to finish this off, the Minister responsible for all aspects concerning the registration of secure units or accommodation, we are focusing now on secure units, was the Cabinet Secretary for Justice?
A. That's right, yes.
You have got two Senior Ministers responsible for secure accommodation, one on the education and care side and the other on the registration side.

Q. The last sentence then:

"Following the establishment of the Care Inspectorate, regulations 3(1) and (2) of the Secure Accommodation (Scotland) Regulations 2013 restated that no secure accommodation may be provided unless it has been approved by the Scottish Ministers under the 2010 Act."

That is a restatement of the position?

A. That's right, yes.

LADY SMITH: Mr MacAulay, would that be a good point at which to pause for the lunch break?

MR MACAULAY: Yes, it would.

LADY SMITH: Very well.

We will stop now for the lunch break and I will sit again at 2.00 pm.

(12.59 pm)

(The lunch break)

(2.03 pm)

LADY SMITH: Good afternoon. My apologies, I am slightly late, I got delayed in a meeting but we are ready to go now. Are you ready to go?

A. Yes, my Lady.

LADY SMITH: If that is okay -- thank you.

Mr MacAulay.

MR MACAULAY: Yes, my Lady.

Yes, good afternoon, Professor.

We had moved on to start looking at secure care and you had explained your methodology to us and I think from the point of view of the case studies, you have identified four case studies?

A. Yes.

Q. Rossie, St Mary's Kenmure and The Elms and we have, to some extent, seen these before?

A. That's right.

Q. The one we have not with you was The Good Shepherd?

A. That's right, yes.

Q. Let's look at Rossie, at page 182. You tell us at the very outset that Rossie underwent an integrated inspection by HMIe and the Care Commission in November 2005 and that formed one of the twice yearly inspections?

A. That's right, yes.

Q. You set out -- perhaps we can dwell on this for a minute or two -- at 4.2, just the nature of the team involved in the inspection. Can we see that there are Care Commission Officers, there is a Care Commission medical adviser, there is HM Inspectors of Education and of course it was conducted along the terms of the selected National Care Standards and quality indicators, so quite a large team of inspectors?

A. Yes.
Q. You set out there what was being examined and who was being consulted, for example parents were consulted in connection with the inspection.

Then if we go over to 4.2.3, do you set out that although the response from pupils, parents and the local authorities were largely positive, there were concerns.

Do you set out the concerns that were highlighted?
A. Right, could I bring out also that, although the inspection was conducted in November 2005, it wasn't reported publicly until May 2006. Which indicates it is a process of producing the report, which indicates that its draft report was circulating between the various inspection agencies and also the provider.
Q. Yes. They would have their own input if so advised?
A. That's right, yes, sorry.
Q. I think you do note that between the date of inspection and date of publication, quite a number of months can go by?
A. That's right, yes. It is not clear what was happening, why it took so long, but I assume there were issues concerning the draft that the inspection agencies and the provider needed to discuss.
Q. In a given case I would imagine the provider might take objection to a finding?

A. Yes.
LADY SMITH: I suppose equally, although the provider may formally be taking objection, the provider will have seen the nature of any criticisms and it must only be human nature for them to act immediately to satisfy themselves that they are up to standard and attend to any failings that have been identified?
A. It is not evident in all cases.
LADY SMITH: No.
A. There are some cases I think we have discussed previously where even the requirements were not being met subsequent to an inspection. It is not clear from this report exactly if there were issues which the provider objected to --
MR MACAULAY: No.
A. -- and the language was toned down.
Sorry.
Q. Is there any indication in these reports that you have been looking at that notwithstanding the fact there is to be a delay in the publication, that the provider, notwithstanding the delay, has begun to act before the report is published?
A. This is some evidence from some of the reports I think we have discussed that, yes, that does occur.
LADY SMITH: They would be wise to do so --

A. If there was a requirement, absolutely.
LADY SMITH: Yes. Even if there wasn't, if there is criticism, why wait until the report is published?
A. Yes, yes.
MR MACAULAY: Any delay leaves at risk issues such as the welfare of children?
A. The safeguarding of the children, yes.
Q. Yes.
A. Yes. Sorry I interrupted.
Q. No, thank you for that.

You were going to take me through the concerns that are set out at 4.2.3. I think there were three areas of concern?

A. Yes.

The first concerned educational needs, the lack of up-to-date information on achievements at previous schools and the failure to develop individualised education programmes. There is clearly a weakness in the curriculum, especially in English, maths and a number of other subjects.

The second related to the quality of accommodation, which the inspectors thought to be stark, oppressive and lacking in comfort.

That is very strong language I think to have in an inspection report, "stark, oppressive and lacking in

comfort".

Q. The third, I think, related to recent staff training in child protection issues?

A. Yes, and I think that is quite a new piece of agenda really to creep into these reports at this time.

Q. Yes.

A. There were 11 recommendations, which would be subject to a follow-through inspection.

Q. Do we note again that there was a reservation over how medication was being recorded and monitored?

A. That's right, yes, and the school was given 10 weeks to implement the requirements.

Q. Yes.

When we look at 4.2.4, this looked quite interesting. Am I correct in thinking that that should read:

"Subject to the integrated inspection, ahead of the publication of the report ..."

The way it reads is, "But published ahead ..."

Are you saying here that before the report, that was subsequently published after the integrated inspection, there was an unannounced inspection?

A. There was an unannounced inspection in February 2006.

Q. That was just shortly after the --

A. The integrated inspection.

Q. And before publication of the report?
A. Before publication of the integrated report, yes.
Q. I follow, yes.
A. The point I was trying to make earlier, there are clearly some concerns regarding Rossie, which resulted in this unannounced inspection in 2006.
Q. Here you have the Care Commission turning up on the doorstep, trying to catch them out, I suspect?
A. Well, if you want to put it that way.
Q. What then did they find in the course of that unannounced inspection?
A. That the staffing levels had fallen below the minimum levels agreed with the Care Commission, usually by one member of staff, there were clearly issues of staff shortages and sickness among education staff, which clearly impacted on the quality of education providing.
Q. Did that finding then prompt a requirement?
A. Yes.
Q. As you set out at 4.2.5?
A. Yes, yes.
Q. It was a pretty tight timescale?
A. An extremely tight timescale, immediate and ongoing, which was an indication that it should happen pretty quickly.
Q. Do we see then that at a meeting between the HMIe and

the Schools Division, there was some discussion as to what should happen next?

A. Yes, the Division, which included the Registrar for Independent Schools, noted that the report was 50-50 in respect of quality indicators. But was uncertain to the extent at which the school was objectionable under the provisions of the 2004 Act.

Q. Yes, and I think the Registrar sought advice on the issue of imposing conditions?

A. Yes.

Q. But it would appear that the HM Chief Inspector was rather cautious about that?

A. Yes, of imposing conditions that --

Q. I think that was a caution based on the practice, I think, as I think we have seen, to allow the school the ability to take forward matters for further improvement?

A. That's right, yes, if there was a capacity there.

Q. If we move on to 4.2.9, it would appear that the HM Chief Inspector had himself, or herself, undertaken a further visit to the school?

A. Yes.

Q. Was this to try and respond to the Registrar's position, and he could come and say to the Registrar that Rossie "... was doing all it can to address the educational

action points"?

A. Yes, this is not an official report that was actually published. This was an internal report. I don't think I found -- if there was a detailed report, I couldn't find it amongst the records, but it is referenced that the lead ASN, HMIe had produced an additional report as a result of a further visit. And, as a result of that, they did believe that the new Depute Chief Executive and Manager were continuing to drive progress.

Q. Yes. Again, the Registrar hasn't given up the thought of going down the conditions route?

A. No. No.

Q. I think you set out the quote that sets that out.

But if we go on to page 186 at 4.2.10, can we see that, again, the HM Chief Inspector has responded by saying, "Imposing conditions at this stage would not help to improve the situation", because, "... the school was doing all it can"?

A. That's right, yes.

Q. This again reflects I think what we have seen in other cases, where they are trying to give as much rope as possible to the provider.

A. And this being a fairly major provider of secure accommodation.

Q. Yes.

The next paragraph I think reflects the same sort of message, namely that the provider should be given the opportunity because considerable work has already been undertaken and to bring about improvements.

Again, that is the message, if you can show you are improving, we can hold off?

A. That's correct, yes. But in 4.2.11, an issue emerges concerning the issue of child protection training which HMIe thought important, but there was, if you like, a technical issue that the Care Commission had not made child protection training a requirement.

Q. Yes. Yes.

Then do we come to a Care Commission inspection in September 2006?

A. Yes.

Q. Here again there are some additional requirements set out; is that correct?

A. That's correct, yes.

Q. What were these?

A. The first is that arrangement must be made for all staff to receive training in child protection appropriate to their roles and responsibilities.

Even although a previous report from the Care Commission had not set a requirement, and even though HMIe had thought it important, right, it was now being

considered important by the Care Commission.

Q. There is also, again, as we have seen before, a requirement in connection with the standard of recording of medication to be improved?

A. That's right, yes.

I don't know the conversation between the HMIe and the Care Commission regarding child protection training, because that is not recorded.

Q. There was also a requirement in connection -- which restated the earlier requirement in connection with the minimum staffing levels?

A. Yes.

Q. We then come to an integrated interim inspection by the HMIe and the Care Commission in March 2007 which, I think, looks a much more positive report?

A. Yes, it should be noted this is an interim inspection, as integrated follow-up inspections usually were 12 months and this is slightly less time.

Q. Yes.

Moving on to 4.2.15, we have another integrated inspection in February 2008. Once again I think we read that very good progress has been made and this is positive?

A. Yes. Yes, and that the decision was no further visit would be undertaken to action of the 2005 inspection.

Q. Then coming to your summary of this particular case study, what do you draw from it?
A. The school was clearly being monitored very closely in relation to the national standards of care accommodation, and a detailed set of recommendations with the requirements to set out ... the deficiencies of the inspections 2005-2006, were an obvious concern to the Registrar of Independent Schools, to the HMIe and CC, but the agreement was that so long as the school managers were given time to institute improvements and had -- and they believed that they could, and would, then they preferred to work with the school managers rather than advising a recommendation for the Scottish Ministers to impose immediate conditions under the Education Acts.
Q. Okay. We then move on, Professor, on page 189, to your case study of St Mary's Kenmure. We have looked previously at St Mary's Kenmure in your last report I think, and what you tell us at 4.3.1 is that in May 2006 it underwent a joint integrated inspection by the HMIe, SWIA and the Care Commission.

A previous review you tell us had raised concerns about the safe care and education of young people --
A. Yes.
Q. -- who displayed sexually harmful behaviour. It would

appear that St Mary's held specialist provision for six such people; is that right?

A. That's correct.

Q. That was a dedicated unit for ...

A. Yes.

Q. The inspection report of 2006, I think you tell us, was generally positive?

A. That's right, yes.

Q. There were, if you turn over to page 190, 4.3.3, there were recommendations and one requirement?

A. That's right, yes, and which again was related to the issue of medication, surrounding medication, personal identification numbers of nurse practitioners with the Nursing and Midwifery Council.

Q. The next inspection in March 2008, which was a Care Commission inspection, it listed no requirements but there was an issue raised about the use of agency staff to fill in staff absences?

A. That's right, yes.

Q. I suppose that creates a lack of continuity and consistency in the care of the children?

A. Yes, if there was a constant change of the actual supervision during the day and night.

Q. You then go on to mention what is described as a significant incident in March 2008, where a young

person locked himself in a corridor toilet --
A. Yes.
Q. -- and the police had to be involved, is that correct?
A. That's right, yes.
Q. I think the position was that the Care Commission concluded that the procedures were followed, including the calling of the police?
A. Yes.
Q. But, like all these incidents that we have seen, the matter got to the ears of the press?
A. That's right, yes.
Q. And the Cabinet Minister for Justice had some involvement?
A. Yes, the Cabinet was informed on the nature of the regime that the government policy was to scrap the law that allows children to be locked up in Scottish jails and consider the use of secure accommodation. The Cabinet Minister was informed that the school was confident that the incident was under control, but would review its procedures and risk assessments accordingly.
Q. It didn't stop there, because I think as you tell us on page 192, it was raised in the Scottish Parliament by the local MSP, and indeed the First Minister responded to that issue --
A. Yes.

Q. -- in the way that you set out there?
A. That's right, yes, that it would be further investigated before conclusions were reached.
Q. Before that incident could be further reviewed, a more serious disturbance occurred?
A. Yes, on two days, 29 and 30 March 2008, a group of young women and others, a number of whom absconded.
Q. And --
A. Extensive damage, setting fires, placing staff and other young people in danger and assaulting a member of staff occurred.
Q. Did this result in particularly those involved being arrested and either transferred to other secure units or transferred to St Philip's, Kibble and Rossie, the other secure units?
A. That is right and the secure service was closed on a temporary basis.
Q. Yes, and you tell us that at 4.3.9?
A. Yes.
Q. Then, if we move on to 4.3.10, after some work was done and there were plans to open the unit, I think you say the Care Commission conducted an inspection and, subject to a series of measures, recommended that the school could reopen?
A. Yes.

Q. In the quote you say:

"As regulatory activity is targeted and proportionate, and the Care Commission prefers to work with providers to achieve good quality care, in the case of St Mary's it was felt that as long as the providers were cooperating with the Commission, as they have done throughout, it was not necessary to invoke mandatory measures."

So it is the same message I think we see on a regular basis?

A. But again it stresses the issue that it should not be reopened by Ministers unless they were content with the advice received from the Care Commission and HMIe.

Q. There was, I think, some concern that the school having been inspected, and yet these disturbances took place, as to whether or not the Care Commission was competent to --

A. Yes.

Q. -- quality assure the school. Is that what you address at 4.3.11 on page 194?

A. Yes, that was a submission that went to the Cabinet Secretary for Justice and the Minister for Community Safety, that, given the positive report in March 2008, there might be some issue regarding the Care Commission's competence to quality assure. The advice

to the Minister was that responsibility rested with the provider, first and foremost, to ensure a safe, secure and quality service, and that the Care Commission's role was to monitor quality.

Q. Then you draw attention to the joint integrated inspection by HMIe and CC in November 2008. By this time, St Mary's had undertaken a phased reopening, since August?

A. Yes.

Q. This is a relatively positive report I think?

A. It is, yes, they seem or appear quite satisfied with the changes introduced and the building work that had been completed.

Q. Although I think there were two requirements imposed that you mentioned on page 195?

A. Yes.

Q. Appropriate training in deescalation and physical restraint and also that the school must ensure that the intercom system in the bedrooms of the young people -- that's really a security issue -- is in good working order?

A. Yes, yes.

Q. The followed-through report at 4.3.15 in March 2010, again you tell us that that was a positive report?

A. It was positive:

"Senior staff identify clear priorities for improvement and clarified most of the roles of senior managers, most young people were motivated, engaged in their learning and appreciative of staff. As a result of that HMIe will conduct no further inspections."

Q. Then your final paragraph where you draw from the case study, what points do you want to draw out of the case study?

A. Clearly, this was a period in which the Social Work Inspection Agency withdrew and therefore, following the memorandum of understanding, it was really a matter between HMIe and the Care Commission to conduct inspections. The Care Commission obviously did every six-month intervals and the rolling programme was joint inspections every four years, between HMIe and CC.

Q. Okay.

A. Scottish Ministers were not routinely informed of the results of inspections and that is pretty evident from where in fact you received at least good or better in terms of the ratings provided.

And that they were only informed in instances where heightened issues of concerns had been raised, particularly in the press or in Parliament.

Q. Okay.

A. Again, it was the preference to work with the provider,

if they were seen to be able to implement the regulatory requirements.

Finally, that there was a revision to the conduct of future inspections, it was clearly, if you actually read the recommendations and the requirements, there was a much greater focus on safety arrangements.

Q. Thank you.

Then you revisit The Elms secure unit in Dundee, I think you had looked at that in your previous report?

A. That's right, yes.

Q. As you remind us in that first paragraph, it was a small unit with a maximum, for the secure unit, of about four children?

A. That's right. I have included this in, although it was a small unit, it is one actually provided by the Local Authority.

Q. Yes.

A. It is not just a voluntary body.

Q. No. I think you tell us that there was a close -- I think we saw this before -- support unit, but that operated quite separately?

A. It operated quite separately but within the same complex.

Q. Yes, but with separate inspections?

A. That's right, yes. Separate registration. The close

support unit was not registered as a secure unit and therefore fell outside the immediate jurisdiction of the Scottish Government, right, so that was inspected by CC on six monthly intervals. It would be inspected jointly with HMIe on a four-year cycle and then there would be separate set of inspections -- it might be in the same period -- with the CC and also joint inspections from HMIe.

Q. I think we saw this before, where you have a mixture of non-secure and secure --

A. That's right, yes --

Q. -- on the same site?

A. -- but subject to different regulatory requirements.

Q. Yes.

You draw attention to an inspection -- this is in paragraph 4.4.2 on page 197 -- by the Care Commission and the HMIe in June 2005?

A. Yes.

Q. Aspects of the environment and in particular educational provision were seen as good or very good?

A. Yes.

Q. But what was not so good was the accommodation?

A. Accommodation facilities were regarded as unsatisfactory. Which is of course I think pretty close to the weakest if not the weakest grade that could be

given.

Q. The bedrooms were described as stark and impersonal?

A. Yes.

Q. Do you get the picture that this is a converted house that is being used to accommodate?

A. Yes. Yes.

Q. No requirements were set, but they did ask the Local Authority, Dundee here, to prepare an action plan.

If we move on to 4.4.5, do we see there was a follow-through joint inspection in September 2007?

A. That's right, yes.

Q. I am just looking -- it doesn't appear that anything happened in between that I can see. That means there was about two years between the two inspections?

A. That's right, yes.

Q. What was the outcome of this inspection?

A. There is no indication why there was such a gap.

Q. Of course you have told us that there shouldn't be that sort of gap?

A. Yes, there was no indication as to why. It may well have been because it was a small unit run by or managed by a Local Authority, but again there were issues of staffing.

Q. Yes, although one would think with such a small unit staffing wouldn't be such a problem, or is it the

quality of the staffing that is the issue?
A. I assume from reading it that the issue concerned the quality of staffing that was provided for this unit.
Q. Okay.

I think we see that there had been significant improvements in the quality of food and also at this point in time, although this seems to change later on, some improvement to the quality of living accommodation?
A. Yes. Yes.
Q. As you say, they were less complimentary on staffing.

The report sets out two requirements, develop a statement of aims and objectives for the service, and there is a deadline given?
A. Yes.
Q. And that the provider must ensure that the review of the security arranged for the service is carried out and appropriate action taken to ensure that these operate effectively at all times. Again there is a deadline?
A. That's right, yes, but a shorter deadline for security issues than for statement of aims and objectives.
Q. Yes. If we move on then to paragraph 4.4.7, do we see here that an incident has happened at the unit which has been reported, I think, to the Care Commission?
A. Yes.
Q. What can you tell us about that?

A. Well, there had been substantial damage to the building, including breaking into the unit's secure courtyard by a young person. It was noted that the Care Commission were not obliged to report this to the Scottish Government, as the young person had not absconded and that no one other than the young person was injured.

Q. Was the plan here that the Care Commission and an architect would visit the unit?

A. Yes, I think it is important to note that the Division accepted one of their officials would also accompany the CCC and an architect, and I assume, or read into that, it is because the building was ultimately the responsibility of the Scottish Government in the sense that they were responsible for the security of the building.

Q. As we read on, in this part of your report, was one of the more serious problems the standard of the accommodation?

A. Yes. The standard of the accommodation was the principal issue.

Q. Did it seem that the Council appeared to be somewhat reluctant to improve the accommodation?

A. Yes. It is not evident from the record, but it would appear, as subsequent events indicated, that in fact Dundee wished to withdraw from the provision of that

accommodation.

Q. That is what happened?

A. Yes.

Q. So the unit closed down?

A. Yes.

Q. Your summary then on 4.4.12, what do you draw from the case study?

A. Again, the inspectors both Care Commission and HMIe prefer to work with the City Council, on the assumption that it was willing and could implement the regulatory requirements. Although the response seemed to be slow, the regime, the inspection regime, again preferred a more developmental approach rather than imposing conditions.

It was an approach endorsed by the Scottish Government after the incident in 2009. As a result of wider changes in development of the secure estate, respective of the Care Commission and Education Inspectors, the decision was to withdraw from the provision of that accommodation.

Q. Yes, and was this secure unit part of the response to the earlier chapter we looked at in connection with the availability of secure units?

A. It reflected Dundee's response, or Tayside then Dundee's response to the incident of the death of the young

person indicated in the previous report.
Q. The lifespan of The Elms was from 2000 to 2012?
A. That's right, yes.
Q. Just 12 years?
A. That's right, yes.
Q. Let's move on to the final case study in this section, that is in relation to The Good Shepherd. Of course The Good Shepherd in a way is clouded by the fact that this was the facility where two young girls came from and committed suicide?
A. That's right, yes.
Q. That is one of the death cases you look at in a few moments. Indeed it resulted in a Fatal Accident Inquiry before Sheriff Ruth Anderson, which reported in 2012.
You describe the setup to us at 4.5.2, can you just explain the layout?
A. The centre comprised three units providing care and education, a secure unit, a close support unit and an open unit. The latter also operating in conjunction with a local day school. So there are three units there.
Q. Three residential units.
LADY SMITH: Just for the sake of the transcript, can we locate this geographically --
MR MACAULAY: I'm sorry, 4.5 --

LADY SMITH: I know where it is geographically, but where in Scotland? It is not mentioned.

A. Bishopton.

LADY SMITH: It's Bishopton, thank you.

MR MACAULAY: Just to understand, I think we all understand what a secure unit is, a close support unit is something that is not wholly secure but nevertheless a closer eye is kept on the children.

A. A close support unit is an intermediary unit, if you like, between an open unit and a secure unit where a young person would be held if you like after a period of time in a secure unit or during assessment before being placed in a secure unit.

Q. Are you able to tell us whether when you have these units and a day school, is the educational provision for the secure unit for example quite separate from the day school or do they all mix?

A. I cannot be absolutely certain, but I think in fact it was -- certainly the secure unit education was meant to be provided separately.

Q. Okay.

You tell us at 4.5.3 that before the deaths of the two girls, the Care Commission conducted inspections of the units on at least two per annum and the results of the inspections were positive results?

A. Yes. Yes.
Q. At 4.5.4, in particular, you identify an inspection in March which, again, looking at the grades that you have identified, was a positive one?
A. Yes. Yes.
Q. At 4.5.5, there is an inspection carried out in connection with the close support unit, and again the report is positive with gradings of either very good or good?
A. That's right, yes.
Q. Am I right in thinking that the girls, or at least one of the girls, was being accommodated in the close support unit?
A. That's correct, yes.
Q. There was I think some thinking that the -- perhaps before I come to that, at 4.5.8 you say in the first sentence:

"The Good Shepherd open unit provided care and education for adolescent girls experiencing social and emotional behaviour and difficulties [the phrase we have seen before] and was subject to a joint integrated HMIe and CC inspection ..."

I think that should be October 2009, in that I have checked the footnote and it relates to an inspection report for 15 and 20 October 2009. Would that fit in

with the context?

A. I think that is -- I would have to double check, but I think there was an earlier report.

Q. But it is not 2003, we are not --

A. No, no.

Q. -- in that timeframe?

A. No.

Q. Okay.

In any event, you tell us that the inspectors graded the school from fair to good?

A. Yes.

Q. But then there was a suggestion that there was an intention to close the school?

A. That's correct, yes.

Q. Is that the --

A. That is the open school.

Q. The open school. But that was reversed?

A. Yes.

Q. There was an inspection, you tell us at the end of the next paragraph on page 204, in March 2009 that resulted in, again, what one would describe as a positive result?

A. Yes.

Q. Again, in July 2009, that the grades remained good?

A. Yes, yes.

Q. I think the suicides that took place were in

October 2009?

A. That's right, yes.

Q. You tell us that the day after the deaths, the Cabinet Secretary was involved?

A. Yes. Was informed, yes.

Q. Was informed.

We see that Cardinal O'Brien was involved, no doubt because of the Catholic connection to The Good Shepherd, that is at 4.5.10. He was, at the time, the Archbishop of St Andrews and Edinburgh.

Yes, if we go to paragraph 4.5.11, this is after the deaths and the fact that, if there was to be an FAI that would be a matter for the Crown, but you also mention here of an interagency arrangement. Can you just elaborate on --

A. Could I just go back to 4.5.9?

Q. Yes.

A. The penultimate sentences there, that on the procedure in relation to the death of a looked-after child, in these circumstances the report says:

"... SWIA stated that work with HMIe and the Scottish Government Health Department to examine the arrangements that had been put in place for the girls' welfare ... in terms of the usual policy of lessons for policy and practice."

Now, I have not been able to locate that report.

Q. I see.

A. Sorry, I just wanted to bring that out, that it is a procedural issue which is actually quite important in a case such as this, that automatically the Social Work Inspection Agency would have to be involved.

Q. All right.

They are involved I think in the interagency enquiry that you mention at 4.5.11?

A. Yes.

Q. Along with COPFS, Strathclyde Police and the Care Commission?

A. That's right, yes.

Q. Do you see here that at this time the Care Commission undertook a further inspection?

A. Yes.

Q. And it set out two requirements?

A. That's right, yes.

Q. You set these out on page 206?

A. Yes.

Q. Can you just tell us what these were?

A. That the provider must demonstrate it has reviewed and where necessary updated all current services users' individual risk assessment to ensure they address all aspects of risks relating to safety of service users.

And that the provider must complete an environmental risk assessment of the security, safety and suitability of the premises on which the service is provider and that an action plan would be necessary, setting out any deficiency noted in the risk assessment relating to the security, safety and suitability of the premises and how these deficiencies will be remedied.

Q. Do we see in the next paragraph at 4.5.12, that a follow-up inspection in January 2010 confirmed that the requirements had been met?

A. Yes.

Q. And indeed that that was generally a positive report?

A. Yes. Yes.

Q. Do we take from that that a detailed action plan must have been submitted?

A. Yes.

Q. The next section at 4.5.13 contains details of a brief that was prepared for the First Minister ahead of any questions being raised in the Scottish Parliament.

A. Yes.

Q. The points I think that were being fed to the First Minister, to explain the position and what had happened, for example, that the Care Commission acted quickly, is the first point?

A. Yes.

Q. We can read for ourselves for example requirements were placed on the service, the Commission had confirmed in follow-up inspection that the centre had met these requirements and so on and so forth.

These were lines really that were being prepared for the First Minister should questions be asked?

A. Yes.

Q. Do we see then that in June 2010 The Good Shepherd board told the Scottish Government that they intended to close the open unit, together with its school?

A. Yes.

Q. Does that mean that it would be the closed unit and the secure unit that would be left behind?

A. That's right, yes.

Q. Finally, we have in paragraph 4.5.15, a briefing I think again for the First Minister in relation to what the Sheriff had found in the FAI?

A. Yes.

Q. As far as the Care Commission was concerned, the First Minister was being briefed that the Care Inspectorate, Care Commission has come in for some moderate criticism and as we go on to read that, is related to the lack of clarity --

A. In the inspection reports.

Q. -- in the inspection reports?

A. Yes, as well as the lack of clarity on exactly how many staff were to be on site.

Q. Yes. Now then, what do you draw from this case study?

A. Well, clearly the three units at The Good Shepherd were subject to the usual Care Commission inspection, in addition to a joint integrated inspection by the HMIe. No requirements were set as a result of any inspections until after an anonymous complaint in 2008 and the requirements placed only affected the open unit:

"It is evident that as a result of the incidents of the deaths of the two young pupils, the Registrar of Independent Schools, SWIA and the Scottish Government's Care and Justice Division, as well as the Care Commission, acted promptly to set in motion a review of the circumstances surrounding the death of the two girls and deduced the lessons for future policy and practice. Scottish Ministers were immediately informed of the actions being taken and supported the initiatives to review the events and the conclusions for the improvement of the regimes."

Finally, ahead of the Fatal Accident Inquiry report, the Care and Justice Division set in motion a policy review to re-examine practice protocols for sharing information, all those looked-after children with a history of absconding and those deemed at risk of

suicide.

Q. Then you have your final overall review. Can you just very quickly summarise for me how you would overview this particular chapter?

A. Yes, clearly initially SWIA were involved but once they reviewed a memorandum of understanding had been reached between the Care Commission and the Scottish Government on issues concerning improvement notice, as similar as residential schools.

There was an expectation that the Government would be informed where requirements had been set.

It is clearly evident here in these case studies that the Care Commission did keep the Scottish Government informed where requirements had been set, as well as at Elms in 2009, where its officials were alerted after an incident, although it wasn't obliged to.

The Scottish Government was kept informed of the disturbance at St Mary's Kenmure and, similarly, worked very closely in relation to the incident at The Good Shepherd.

Q. Okay.

A. I think it should also be said that of course the Registrar of Independent Schools' role in advising Scottish Ministers on registration issues was enhanced

as a result of the 2004 Act. And the Act widened the power of Scottish Ministers to issue complaints or cancel a registration. The inspection reports formed the central focus for the Registrar ahead of recommendations for Scottish Ministers, as can be seen in The Good Shepherd in 2009.

Q. Thank you.

We come then to the final chapter or section of your report and that is dealing with deaths of looked-after children in care. You look, I think, at eight separate cases of deaths and, again, we have looked at the process, if you like, previously.

A. Yes.

Q. I don't think we need spend too much time on the introductory sections. The guidance, did it significantly change from the previous position up until the period you are now looking at?

A. My understanding is that in fact when undertaking the review of death, Ministers were unable to examine and review in the same format as previously. This dated really in essence back to 1962, as I think previous reports have indicated.

Q. What has changed during this period is to which Inspectorate becomes responsible for looking at deaths, and it became the Care Inspectorate in 2011?

A. That's right, yes. It was the same inspectors who had inspected under SWSI continued -- from what I have seen in terms of names -- the same role once the Social Work Inspection Agency was formed, it was the same inspector, or the same group of inspectors.

My understanding is that that group of inspectors moved over or was incorporated within the Care Inspectorate in April 2011.

Q. Yes. You do raise a point, I think you call it a constitutional point --

A. Yes.

Q. -- that may not have been fully appreciated, that the Care Inspectorate was different to the Care Commission, in that it was a separate body corporate and not an executive limb of the --

A. You meant the Social Work Inspection Agency.

Q. Yes, you are quite right.

A. Yes.

Q. You address that in particular I think at 5.1.11 on page 214, where you set out in quotes that there was no specific legal obligation for the Care Inspectorate to notify the Scottish Ministers of deaths of looked-after children?

A. That's right.

Q. Can you just develop that and how that came about,

because of course Local Authorities were under a duty to notify Scottish Ministers?

A. Yes, my reading of the material, that is correct. What is stated there in that minute from the Care and Sponsorship Team, Care and Justice Division and other officials, that the Care Inspectorate may notify but were not obliged to do so. And that the Local Authority could continue to notify the Care Inspectorate, but that did not equate to notifying Scottish Ministers, right?

Local Authorities were still required to notify Scottish Ministers, but they were notifying the Care Inspectorate. My assumption is that that is because the same body of Social Work Inspecting Agency officers shifted to the Care Inspectorate and simply local authorities said, "We will just notify them, it is the same individuals".

LADY SMITH: And they were assuming that somehow it would make its way to Scottish Government by doing that?

A. Somehow it would make its way to the administrative officials, right, who would then in critical cases, inform Scottish Ministers, who could then issue a closure letter.

MR MACAULAY: Yes, but of course, as you point out at 5.1.4 on page 211, the requirement to notify Scottish Ministers of the death of a looked-after child was

restated with the Looked After Children (Scotland) Regulations 2009, and that placed the duty on Local Authorities.

A. Yes.

Q. So they were in breach of the regulations in not so doing?

A. Yes. And the regulations continued even after the establishment of the Care Inspectorate.

Q. No doubt, as you have said, in mitigation they would say, well, we thought in telling the Care Inspectorate we were effectively telling the Scottish Ministers?

A. Yes.

Q. Did this then result in a change in regulation to in fact impose a duty on the local authorities to report also to the Care Inspectorate?

A. Yes.

But, right, there is no evidence that the Local Authorities were sending a separate note to the Scottish Government. Again, what that states in 5.1.11, the legal obligation for the CI to notify Scottish Ministers was not altered.

Q. No. No, it remained there?

A. It remained that, yes.

Q. Just on the closure point that you mentioned, I think in the past we have seen that when the investigation into

a death in care has been concluded, that there is a closure letter --

A. That's right, yes.

Q. -- sent out.

Are you saying that there is not so much evidence of closure letters, post the establishment of the Care Inspectorate?

A. I have seen no evidence of a closure letter coming from Scottish Ministers, right. I obviously didn't have sight of the Care Inspectorate's material, so I have no idea whether closure letters were sent by them.

Q. The closure letter should have been sent by the Scottish Ministers?

A. On behalf of the Scottish Minister.

Q. Yes.

A. The important thing is that going back in time, closure letters could be sent by the Social Work Services Inspectorate, and its subsequent body, Social Work Inspection Agency, on behalf of Scottish Ministers but they were officers of the Scottish Government.

MR MACAULAY: Yes.

Very well, I am about now to move on to look at individual cases.

LADY SMITH: I think we should maybe take the mid-afternoon break now, Mr MacAulay.

We will do that and I will sit after we have had a short breather.

Thank you.

(3.00 pm)

(A short break)

(3.11 pm)

LADY SMITH: I hope that was enough of a breather for you Professor, are you ready for us to carry on?

A. Yes, thank you, my Lady.

LADY SMITH: Thank you.

Mr MacAulay.

MR MACAULAY: Yes, my Lady.

Can we look at the cases you have selected for the various different case studies for deaths.

The first three cases, the first two involve very young children?

A. Yes.

Q. With I think what one would describe as post-natal complications?

A. That's right, yes.

Q. These were looked-after children, they were not in residential care?

A. No, that's right.

Q. Likewise, the third case was a 15-year-old boy who had I think been in foster care and suffered from I think

cerebral palsy -- yes, dystonic cerebral palsy?
A. Yes, that's right.
Q. As far as these cases are concerned, I don't think any issues arise out of these?
A. No, I included them as examples to indicate the range of reviews that were undertaken.
LADY SMITH: Of course.
MR MACAULAY: Case 4, which you will find on page 223, this is a boy who died in residential accommodation at Geilsland in January 2008 at a time when I think he was aged 16 or 17.
A. Yes, that's correct.
Q. We dealt with Geilsland earlier on.

He had difficulties in the sense he had dyslexia and learning difficulties and he also suffered from diabetes; is that right?
A. That's correct, yes.
Q. There had been a suggestion in the past, if you look at page 5.5 towards the end, that there had been a failure to provide an educational psychologist for a period of nine months?
A. Yes, yes.
Q. He did suffer from behavioural issues as well; is that right?
A. That's right, yes.

Q. But he seemed to have been progressing during his time at Geilsland?
A. That's right. The reports do indicate, you know, that progress had been made.
Q. If we look at 5.5.4, can we see that what has happened here is that CrossReach had intimated that, on the night of the boy's death, I think he died in the home --
A. Yes.
Q. -- that two of the three members of night staff may have been asleep. Do you see that?
A. Yes, that's right, yes.
Q. The cause of death, I am just looking at my notes, was it to do with the fact that he hadn't been taking his medication --
A. That's right, for diabetes.
Q. Yes, death apparently is from natural causes related to diabetes I think is the cause of death?
A. That's right.
Q. At 5.5, the failures that were being identified were in relation to the procedures at night where staff may have been asleep and because of that the night care team leader was suspended?
A. Yes. Yes.
Q. The Registrar concluded by noting that CrossReach had taken the appropriate course of action and that it was

working with the agencies concerned with the boy's care to take matters forward?

A. Yes.

Q. Do we then see that in April 2010, CrossReach forwarded its report to the Significant Care Review, to the Care and Justice Division and sought advice on four specific recommendations?

A. That's right, but if you notice also on 5.5.6, that the information regarding the death was also submitted to the Cabinet Secretary --

Q. Yes.

A. -- who expressed their gratitude for the update.

Sorry.

Q. In relation to the recommendations that they sought advice on, do you set out on page 226 the response?

A. Yes.

Q. We can perhaps summarise what that was?

A. Yes, that a Nurse Director had been appointed to lead a health activity hub, sorry, to resolve the persistently unsatisfactory health outcomes experienced by young people in care. That is an area officer.

On the second recommendation, which is then multi-agency guidance to support staff assessment and management of risk presented by non-compliant behaviour for young people with complex health needs, that the

recently reviewed child protection guidance covered a section of young people who placed themself at risk.

Q. This young boy had put himself at risk essentially by not taking his medication for diabetes?

A. That's right, yes.

Q. You do make a number of comments in connection with this particular case at 5.5.8; what do you draw from it?

A. I think the first thing is that the Education Inspectorate were clearly aware of the issues at CrossReach and that the issues were quite deep seated.

The Education Inspectorate had looked very closely at the boy's records and the behaviour and that they had made considerable progress.

Third, that the decision to establish a Serious Case Review, internally, if you like, prevented the Registrar of Independent Schools and the Care and Justice Division conducting further investigations. By the time the review was published, the Government had already sought to address the issues which the case had brought out.

Q. Yes.

A. And that SWIA had asked that the Local Authority should review all risk assessment and management plans for each child at risk of self-harm and that night staff's role, I think importantly in this case, should be recognised in training supervision and in management support.

Q. Okay.

Then the next case you look at, Case 5, here we are looking at Ballikinrain, which is another CrossReach establishment. This was a case where a boy, one of its residents, was found dead in a nearby quarry and he was aged 16 at the time, is that right?

A. That's right, yes.

Q. His death was essentially caused by the result of the fall?

A. Yes.

Q. The background to this, I think, is that he had been consuming alcohol before he went to bed. Is that correct?

A. That's right, yes.

Q. I think he was being observed up to a point, when it was thought that he had made a reasonable recovery from his alcohol consumption?

A. That's right, yes, and had gone to sleep.

Q. He had been making good progress I think in his time in Ballikinrain and I think he had been there since 2008?

A. That's right, yes, he had been under care for some time.

Q. When one looks at the file, and when his body was recovered, I think a letter was found --

A. Yes.

Q. -- which purported to be his last will --

A. Yes.
Q. -- but I don't think any conclusion was arrived as to whether or not it was a simple fall or not?
A. Or a deliberate act.
Q. Yes, no.

If you turn to paragraph 5.6.5, there you set out the fact that the Procurator Fiscal had concluded that there were no apparent suspicious circumstances, otherwise as I have mentioned the boy had left a letter note which expressed his last will. I don't think there was any further action taken?

A. No, no, no, no.
Q. One of the sad things about this case, I suppose, is that he was taken into care because of the background of domestic violence with the family home when alcohol was a feature, and he had been in care since the age of nine in different places?
A. That's right, yes.
Q. What comments do you draw from this particular case study?
A. As again in previous cases, the Registrar of Independent Schools had immediately informed the Cabinet Secretary of Education and Lifelong Learning of the details and indicated that they would keep the Cabinet Secretary informed, especially as it related to any issue of

school governance.

The Junior Minister for Children and Young People sought to be kept updated at regular intervals on this and other cases and the school forwarded its critical incident review to the Registrar, which with the information from the care inspector resulted in no further action by the Scottish Government on the school's governance. They were clearly happy and satisfied.

Q. Okay.

A. There was obviously a very detailed report from Education Scotland on the boy's personal and educational circumstances, which again confirmed there were no issues confirming the school's governance.

Q. Then the next case concerns a young girl who again was not in residential care but she was subject to a supervision requirement, residing at home with her parents. She was 15 and she died after a fall, a 60-foot fall, from a block of flats in July 2012.

A. Yes.

Q. Again in the file, you haven't spelt this out but when one looks at the file, there is at least a suggestion early on that she may have jumped?

A. Yes, that's right, yes.

Q. She had been drinking, as you point out, and had been

having an argument with others.

A. That's right, yes.

Q. One of the tragedies of this case is that her elder sister, you tell us at 5.7.2, had committed suicide the previous year?

A. That's right, yes.

Q. Again, there was no Fatal Accident Inquiry here, was there some concern that this girl, this young girl, was in an environment where she was exposed to overindulgence in alcohol?

A. Yes, given the family circumstances the issue was to what extent should additional protection should be -- had been offered to the child.

Q. Yes. Yes.

When we look at 5.7.8, what do you draw from this particular example?

A. Again, Government officials responded immediately to the incident, to ensure that the Minister of Children and Young People were aware of the circumstances. Clearly there was concern in terms of the press interest. The Minister was reminded again by officials that investigating and reporting on the death lay outside the Scottish Government's remit, it was there simply to review the circumstances, particularly the support being offered to a child before their death.

The Minister clearly exhibited some concern and that was satisfied that discussions with the relevant groups and agencies were already underway for similar circumstances.

Q. Then the seventh case that you look at, this is the penultimate case?

A. Yes.

Q. It is, again, tragic and quite well known, I think, having been well covered in the press in the past, but this was a case where a one-year-old infant was found dead in March 2010 at his mother's home. The precise date of death could not be ascertained, but that may have happened seven to eight months previously. I think that was because of the state of the body when it was recovered?

A. Yes.

Q. The mother had had a long history of drug and alcohol abuse and I think what happened was that she had dropped out of sight, so to speak?

A. Of the system, yes.

Q. She was prosecuted and found guilty of murder and also an attempt to evade the course of justice, but after an appeal, the conviction was quashed.

A. That's right, yes.

Q. It clearly was a very sad case?

A. Extremely sad, yes, in the circumstances.
Q. As you point out, at paragraph 5.8, one of the problems was that she had dropped off the radar and in particular she had no involvement with the social work services in the period prior to the infant's death?
A. That's right, yes.
Q. That was compounded by the fact that -- no doubt through her misuse of drugs -- she had a significant number of missed appointments with social workers and medical people?
A. That's right, yes.
Q. There had been, as you point out, an HMIe joint inspection of services of Renfrewshire County Council in April 2018. Published I think you tell us in October.
A. Yes.
Q. In the main, that was a positive result?
A. It was positive, with one caveat which is stated, that staff should get involved in at an early stage when there are child protection concerns and that improvement should be made to the monitoring arrangements for medical examinations to ensure children's needs are being fully met.
Q. That perhaps anticipates in a sense the problems with this lady --

A. That's right, yes.
Q. -- who did not keep in touch herself?
A. Yes.
Q. Likewise no one got in touch with her, basically?
A. No one got in touch with her.
Q. There was an FAI in this particular case, and again Sheriff Anderson was the sheriff. She reported in September 2014, you deal with this at 5.8.11, page 237.
A. Yes.
Q. She identified two defects in the system which she concluded contributed in the death?
A. Yes, there was no system in place where one of the agencies responsible for a child's wellbeing was in overall charge and no system whereby one named individual was responsible, coordinating all available information. This resulted in no interagency meetings, particularly during the period when the child was most at risk.

If such systems had been in place, then those responsible for the care of the child would have been fully aware of all that was happening and not happening and taken steps to ensure the child's safety. There was no system in place in relation to obtaining medical information, there was a fundamental lack of knowledge by social work staff at the Royal Alexandria Hospital as

to what information they were entitled to and how they might obtain it. And further issues concerning the approach taken by various professionals in regard to the information surrounding this girl.

Q. You set out at 5.8.12 on page 237 what the Sheriff's recommendations were, and in particular the need to have regular and ongoing assessment of the staffing of child protection services. Second, that priority should be given to any notification of concern on an unseen child?

A. That's right, yes.

Q. Third, that GPs should provide social care and health staff with all relevant medical information of substance --

A. Yes.

Q. -- misusing periods.

Finally, that all staff within the area of child protection should undergo training in the latest guidance and related service protocols?

A. That's right, yes.

The Sheriff added that the Care Inspectorate should revisit Renfrewshire.

Q. And they did that?

A. Yes.

Q. If we go to page 238, we will perhaps pick up on this inspection at 5.8.14. This, again, is a services

inspection --

A. Yes.

Q. -- rather than an establishment inspection?

A. That's right, yes.

Q. This was of Renfrewshire, between December 2014 and February 2015, what was its conclusions?

A. It indicated that clearly some changes had occurred, that children and young people in need of protection were helped to keep safe and risks to their safety and wellbeing were identified timeously by effective multi-agency action, supported by early information sharing and proportionate management of risk.

Q. Your overall view of this particular case study, what do you draw from it?

A. Although this was not strictly speaking a death in care, the evidence suggests it should have been a review of death in care.

Q. The child should have been in care, but wasn't?

A. Precisely, yes. There were obviously serious defects in the system to protect the infant. There were obviously some issues surrounding the joint inspection in 2008. It seemed to indicate high confidence, although there were caveats to it. Again, the follow-through inspection in 2010, published in January 2011, confirmed that the area had maintained a high standard of service

provision, where the indicators were again rated good or better.

But the Serious Case Review restated the view that the HMI report 2008, there were significant issues surrounding the coordination of services and in multi-agency working. It was a view shared by the Care Inspectorate in their evaluation of the implementation of the SCR's recommendations.

It was also the view of the Fatal Accident Inquiry, which resulted in new guidance on child protection being issued in 2012.

Q. Then the final case you look at brings us back to The Good Shepherd case?

A. Yes.

Q. At 5.9, page 239. We have already looked at the setup at The Good Shepherd. What you tell us here is that following the death of the girls who fell to their death at the Erskine Bridge in October 2009, the FAI heard evidence from two Local Authority social work departments, because one of the children had been placed there by Argyll and Bute, whereas the other had been placed by an English council, Hull City?

A. That's right, yes.

Q. You set out some of the comments that the Sheriff made falling up on the FAI -- in the determination, rather?

A. I mean I think the key thing is the quote from the Sheriff, there are several examples of witnesses placing far too much emphasis on whether the child wanted rather than exercising their own professionalism by carrying out a proper assessment of the situation, so that the risk assessment was more orientated to what the child was thinking rather than based on their own professional judgment.

Q. This point that she says, where she says:

"It is difficult to understand in the face of all the evidence pointing towards a different recommendation why Argyll and Bute chose to recommend to the panel on 3 July that the girl should transfer straight from the secure unit to ..."

I think that is the closed unit?

A. That's right, yes, I think so.

Q. Is this the case that the girl didn't want to go from the secure unit?

A. That's right, yes. Yes.

Q. Do you see this as a criticism of the Local Authority?

A. I think it can be stated, yes. Yes. Yes. The Sheriff's statement "it is difficult to understand", is an indication of criticism.

Q. She goes on to say:

"Had there been proper communication among all those

involved in this decision-making process, then one can conclude with confidence that the girl would never have been transferred straight from the secure unit to the other unit."

A. That's right, yes.

Q. You then, from 5.2 onwards, to I think 5.9 -- so it is 5.9.2, through to 5.9/7, you identify a number of performance inspections of Argyll and Bute?

A. Yes.

Q. Beginning with a period in 2007, and I think leading up to shortly before the deaths in 2009?

A. That's correct, yes.

Q. Can you just summarise that for me, because I think there are some important points that come out of that, that are relevant to the deaths?

A. Yes, the Social Work Inspection Agency report, that is of all social services not just childcare, had some concern that the care plans for looked-after and accommodated children should have targeted outcomes, which would be monitored and reviewed.

The follow-through inspection, conducted a year later, noted that the single agency training in care planning but training in multi-agency care planning to enable shared assessment between the various services had not been implemented. Clearly indicating some

concern about joint access to enable staff to implement assessment information and integration of such teams in child protection.

The report indicated that there should be some review of that locally, and a more systematic and comprehensive report -- approach to the assessment and management of risk.

A second follow-through inspection in February 2009 confirmed that good progress had been made, but noted that there were still issues concerning that these were plans, rather than actual working arrangements, basically.

Q. I think you say some staff in fact were unaware of the --

A. Yes, yes.

Q. If you go to 5.9.6, this was the first HMI joint inspection?

A. That's right, that is of children's services.

Q. Yes. Again we are looking at services?

A. Yes.

Q. This was between October and November 2006?

A. That's right.

Q. One of the conclusions, in its summary, the report concluded:

"Further work was required to improve the assessment

of risks, the effectiveness of planning and the involvement of children, young people and their families in developing services to meet long-term needs."

That is quite important?

A. It is important in relation to what the Social Work Inspection Agency were saying.

Q. We then have reference to account being taken of long-term needs --

A. Yes.

Q. -- resources and approaches to monitoring.

If we look at how you have summarised these, I think there were five all together, inspections of Argyll and Bute that you have covered in these sections, at 5.9.8, page 282.

A. 5.9?

Q. 5.9.8, you have set out probably a summary:

"The inspections completed by SWIA and HMIe in early 2009 appeared content that 'given the level of progress achieved' and with the 'strong and increasing commitment from senior managers', social work and the efficiency of child protection services would continue to improve. However, the reports noted certain concerns with children's services especially in the areas of risk management, care planning and arrangements from multi-agency working."

That has been the constant theme I think in these reports.

A. That's right, it is a conditional comment --

Q. Yes.

A. They had been moving but there were clearly issues of concern that remained in terms of assessment of risk management and care planning.

Q. Yes.

If you turn to page 243 at paragraph 5.9.10, do you set out there an update had been given to the Minister on the key messages which had emerged from the FAI from the evidence presented. Are these messages quite telling when you look at the inspections?

A. When you look back at the previous inspection reports, you can see, well, I can understand the concern within the FAI report that in fact the plans that have been recommended and were in progress had not been fully implemented.

Q. Yes. So the Sheriff, one of the key messages that has been taken from the Sheriff's determination:

"Transitions for both girls were poorly planned by social work staff. That professional practice supervision in the social work team in Argyll and Bute was inconsistent due to work pressures, that staff morale was low and the social work team was

under-resourced at Argyll and Bute Council, that interagency communication, recording and information sharing were less than satisfactory. That the concerns of the girl and her mother were not listened to consistently and this impacted on the care she received."

That is a summary --

A. It is a summary, yes.

Q. But then, as you point out, at 5.9, that summary essentially reflects --

A. Yes.

Q. -- what the inspections had uncovered in the service's inspections?

A. Yes.

Q. If we move on to some further comments in connection with the FAI at 5.9.18, the Sheriff again sets out aspects of the failures on page 246 and in particular a failure of placing authorities to hold detailed comprehensive, concise and readily accessible information relating to an individual child to include the recommendations of the child's worker, key worker and any psychological assessment, and to ensure this information was copied to the residential establishment on any placement of the child?

A. That's right, yes.

Q. Do you then tell us that there was an inspection at 5.9.19, via the Care Commission, a joint inspection, over a period of three weeks --

A. Yes.

Q. -- between March 2013 and April 2030. What was the conclusion there?

A. This was about the Care Inspectorate, who had assumed responsibility for the joint inspection of -- sorry, yes.

Q. Yes.

A. It noted in terms of how well are services working together to improve the lives of children, young people and families, the report noted that overall staff recognised circumstances when children might be at risk of harm and usually take prompt action to protect them. Suitable accommodation is provided for children and young people who need to be cared for in a safe place.

Staff have chronologies of significant events. However, they need to improve in how they use these to identify concerning patterns and risks to children and young people. Additionally, there were comments on health assessments and the quality of assessments of risks that needed to be improved, as they remained too variable.

Q. Broadly positive, but --

A. Broadly positive but clearly work still needs to be done by the Local Authority.
Q. Then your overall review of this particular case study, what can you draw from that?
A. Well, it is evident that there were, before the event, a series of inspections by the Social Work Inspection Agency, HMIe that set out some concerns but generally provided good quality grades for the Local Authority. That was obviously revisited once the death had occurred, or deaths had occurred, and it was certainly underlined by the results and conclusions of the FAI.

It is evident that Ministers took a very active interest in the death and the extent to which the Local Authority was improving the quality of services.
Q. Going back to the comparison you draw at paragraphs 5.9.10 and 5.9.11. In particular the comparison between what you can take from the inspections and what the Sheriff found in the determination --
A. Yes.
Q. -- does that tell us anything about the response or responses that Argyll and Bute were making to the findings of the inspections that were being carried out?
A. There is evidence or at least they are reporting some work or there is work in progress, but nowhere near the expectations of what the inspection reports expected.

Q. The inspection reports began I think in 2007 --
A. Yes.
Q. -- and carried on through towards the -- shortly before the death of the girls?
A. That's right, yes.
LADY SMITH: The non-Argyll and Bute girl had been placed by, was it Hull social services?
A. That's correct, yes.
LADY SMITH: Was there any indication in the records you looked at of the Scottish inspectors or social workers engaging with the Hull end, who no doubt were also interested in what they could find out, although they wouldn't have had any power of inspection in the Scottish system.
A. My reading of the file would indicate that the Social Work Inspection Agency did not have a remit to cover the Hull end --
LADY SMITH: No.
A. -- and that was a matter for the English inspection agency to review the case. There is nothing in the file which suggests that any information was sent north.
LADY SMITH: So the Scots end may have been left in the dark about, for example, relevant factors in the Hull girl's background?
A. Well, there were similar issues in terms of the care

being provided --
LADY SMITH: Yes.
A. -- and the risk assessment being provided for that particular girl.
LADY SMITH: Is that a particular risk that has to be taken into account, namely that where a child from outwith Scotland is placed in a care institution or care system in Scotland, they just may not have all the information they would have if it was a Scottish child?
A. That would appear to be the case -- I can't say that the information was not shared, all I am saying is I could not locate a report coming from England to indicate any similarity.
LADY SMITH: Hmm. It might call for something similar to a memorandum of understanding system to be put in place for example?
A. Yes. Yes. There might be similar conclusions as to improving the quality of services.
LADY SMITH: Yes. Thank you.
Mr MacAulay.
MR MACAULAY: Now then, Professor, we come to the last lap, on page 250, where you set out some broad conclusions for this report.
I think we can deal with these relatively briefly. Can you perhaps pick out what you consider to be the

primary issues.

A. It is certainly the case that the various inspection agencies provided officials within the education department and subsequent departments with copies of their inspection reports ahead of publication.

Certainly where reports indicated issues of concern, they were supplied with that information. As a result, Scottish Ministers were routinely informed of the results of inspections where quality grades were rated negative or otherwise deemed unsatisfactory. That is within the inspection of Local Authority services generally and children's services generally.

The evidence suggests that Ministers were prepared to insist on the implementation of the report's recommendations and especially requirements, if thought necessary, and they were certainly prepared to meet and in some cases insisted on meeting Local Authorities and allied agencies concerned.

The same process is evident in review of the joint inspection of boarding and residential schools. The joint inspections were typically on a four-year cyclical basis, this tapered off certainly by the middle of the period under review for independent schools, unless there was evidence of concern.

Only a very small minority of independent boarding

schools were rated unsatisfactory or otherwise regarded as requiring action by Scottish Ministers.

Again, only a small minority of ASN schools were rated unsatisfactory or otherwise regarded as requiring action by Scottish Ministers.

The routine of inspections was on a four-year basis, unless there was evidence of concerns when there was a combination of joint follow-through inspections, interim follow-on inspections and so on.

The joint inspections of secure units of accommodation were subject to the same process of administrative and ministerial review.

There was the memorandum of understanding between the Care Commission and the Scottish Government, a clear protocol for sharing information of issues of concern.

The evidence suggests throughout the period that officials in the Scottish Ministry remained determined that the provision of care should reach quality standards that were rated good or better.

It is evident that where an inspection resulted in recommendations for improvement in safeguarding and in the provision of care, Ministers were prepared to await the results of any further inspection before taking action.

The focus of ministerial tension in such cases

rested on the Local Authority or other agencies instigated management actions on its organisation and staffing. If subsequent inspections resulted in quality grades that were good or better, Ministers seemed to be content with the outcome.

Ministers were also regularly informed by Social Work Inspection Agency, and later CI, in cases of deaths of looked-after children where issues of concerns relating to safeguarding and the quality of provision appeared an issue.

Similarly, officials reacted very quickly where there had been local SCR or FAI reports. Including details of Government and Scottish policy towards the prevention of suicide, the establishment of interagency hubs to improve local coordination of health services and the provision of child protection guidance.

Clearly I wasn't able to review the in-house material of Social Work Inspection Agency or CI inspection reports, as they were all bundled together somewhere in Dundee I have to say. The evidence suggests that the appearance(?) went to a more holistic approach to the inspection of services, focused on the need for inter disciplinary and multi-agency approach in service provision. Collaborative working across agencies was seen as the goal. I would say that

Scottish Ministers certainly on the evidence were more regularly and directly involved in the process of seeking to improve standards of care.

MR MACAULAY: Thank you, Professor Levitt, that brings you to the end of your evidence for today.

Indeed, you have now presented your fourth and final report. It has been a significant effort, you were of course instructed to do this by the Scottish Government, not by the Inquiry directly, but you have made a massive contribution to the Inquiry and provided a real insight into how the inspection process worked.

Thank you very much.

A. Thank you.

LADY SMITH: My thanks as well, Professor Levitt. This has been a tour de force, you don't produce reports like this without dedication and hard grit and the ability never to lose your resilience, I can see that.

You have obviously not just mined the records you have been able to get hold of for all information that is relevant to us, whoever's interest you are thinking of, but you have also thought about it carefully and I am really grateful to you for offering the reflections that you have done where you have. So helpful to have heard you do that.

I can now let you go. When Mr MacAulay said "for

today", I am sure your heart sank, I wondered if he had a surprise up his sleeve for you, but if he does I am not aware of it and, as far as I am aware, that is my final thanks.

I am very grateful.

A. Thank you.

LADY SMITH: Mr MacAulay.

MR MACAULAY: My Lady, that concludes this particular tract of expert evidence and I think we resume again in August.

LADY SMITH: August. We resume for hearings in August on the Edinburgh Academy case study.

MR MACAULAY: Yes.

LADY SMITH: Thank you.

(3.55 pm)

(The Inquiry adjourned until a date to be confirmed)

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