

## **Scottish Child Abuse Inquiry**

Witness Statement of

**Graham DONALDSON**

Support person present: No

1. My name is Graham Hunter Carley Donaldson. My date of birth is [REDACTED] 1946. My contact details are known to the Inquiry.

### **Background**

1. I completed an Honours degree at Glasgow University and qualified as a teacher in 1970. My first job was teaching at a secondary school in Glasgow. Interestingly, at that time there was a scarcity of teachers and the school was something like fifteen teachers short. After graduating, I obtained a Master's in Education in 1975.
2. Following the raising of the school leaving age I was appointed to a team that was developing new approaches to teaching and learning and preparing resources for teachers of young people who were to be compulsorily staying on in education until they were sixteen. I taught in a variety of schools across what was then Dunbartonshire County Council. I was subsequently appointed to a national body called the Consultative Committee on the Curriculum (CCC) and employed by Jordanhill College of Education as a lecturer in Educational Psychology.
3. In my appointment to the CCC I had responsibility for evaluating national curriculum projects across the curriculum, not just in my own area of specialism. That work showed me the possibilities for enhancing the education of young people at a national level. I saw that within HM Inspectorate of Schools there were opportunities to carry that focus on as well as working directly with individual schools and their pupils.

4. I joined Her Majesty's Inspectors of Schools (HMI) in 1983. I became head of the retitled Her Majesty's Inspectorate of Education (HMIE) in Scotland from 2002 until 2010 and in that capacity I was Chief Professional Advisor on Education to the Scottish Government.
5. Subsequent to my retiring from the Inspectorate I became a Professor at the University of Glasgow and undertook work for the Organisation for Economic Co-operation and Development (OECD), carrying out international reviews of four countries: Sweden, Japan, Australia and Portugal.
6. I also undertook a review of teacher education in Scotland and produced a report called 'Teaching Scotland's Future'. The Scottish Government accepted its fifty recommendations. That led to major changes to the approach in how teachers were recruited and trained.
7. In 2014, I was approached by the Welsh Government and asked to undertake a personal review of the national curriculum and assessment arrangements in Wales. I did so and produced a report in 2015 called 'Successful Futures', which made sixty-eight recommendations, all of which were accepted by the Welsh Government. Since 2015 I have been working with the Welsh Government on a major reform of their education system, following on from my report.

#### **Positions with HMI and HMIE**

8. The Inspectorate's structure was slightly unusual in that there was a layer of Chief Inspectors looking after substantial areas of the Inspectorate's work. They had responsibility for District Inspectors, Reporting Officers and those carrying out general inspections. Above the Chief Inspectors (HMCI) there were two Depute Senior Chief Inspectors (HMDSCI) and then the Senior Chief Inspector (HMSCI). All are related to civil service grades.
9. After joining HM Inspectorate in 1983, I carried out general inspection, which included subject inspection of my own specialism. I also acted as the Reporting Officer for

inspections, coordinating inspections of both primary and secondary schools, and participating in wider thematic studies of aspects of education.

10. The Inspectorate was the lead on the development of the new Standard Grade qualifications that were being introduced at the time and I was thereafter attached to the then Chief Inspector and based at New St Andrew's House in Edinburgh to work with him on that.
11. After that work I moved back to Glasgow in 1988 and became a District Inspector in the Renfrew and Ayr Divisions of Strathclyde Region. In 1990 I was appointed as Chief Inspector with responsibility for the Inspectorate's Northern Division, which included everything from Tayside to Shetland.
12. In 1996, I was appointed as HM Depute Senior Chief Inspector and moved back down to Edinburgh. In 2002, I was appointed head of the Inspectorate as HM Senior Chief Inspector and I carried out that role until I retired from the Inspectorate in 2010.

#### **Other staff**

13. When I came into the Inspectorate I undertook a range of roles across education. Where I had not had previous direct experience, notably primary and special school inspections, I was given extensive training. Over my years with the Inspectorate I had varying levels of managerial responsibility for other staff. As a 'Reporting Officer' you have responsibility for a team of Inspectors undertaking inspection of a school. That is not a formal management role in the sense that a Reporting Officer does not have line management responsibility, but you are in charge of that inspection. In my work both while I was attached to the Chief Inspector at New St Andrew's House and as a District Inspector I had responsibility for deploying HMI and overseeing their work, although I had no formal line management responsibility for them.
14. When I became HMCI in Northern Division I had responsibility for the team of inspectors who worked there. I think there were around twenty Inspectors at that time between the three offices in Dundee, Aberdeen and Inverness and there were also

administrative and support staff. I had first-line responsibility for District Inspectors and oversight and counter-signing responsibilities for the remaining Inspectors.

15. As HMDSCI I had initial responsibility for the line management of all Chief Inspectors, with the Senior Chief Inspector being the counter-signing officer. As HM Senior Chief Inspector I had line management or counter-signing responsibilities for HMCIs and assistant chief inspectors.
16. When I became HMSCI I made a number of changes to the structure of the Inspectorate, including removing the role of Depute Senior Chief Inspector and putting in a new layer of Assistant Chief Inspectors. The new role extended career advancement opportunities for HMI and was largely operational, including a staff management role.

#### **Recruitment of staff**

17. Under law, the title of Her, now His, Majesty's Inspector of Schools (HMI) is a Privy Council appointment. Symbolically, that is very important because it distinguishes HMI from other civil servants and is a way of enshrining the independence of the Inspectorate. The appointment of Inspectors operates within standard civil service HR procedures. As HMDSCI I was involved in all HMI appointments and chaired the interview panel.
18. On taking up the post of HMSCI I continued my involvement in every HMI appointment, although hitherto the Senior Chief Inspector had not been directly involved in recruitment. My logic was that there was nothing more important to the organisation than the quality of its people. The reputation of HM Inspectorate and the way in which it discharges its responsibilities are critically dependent on the individual quality of each HMI. A very intensive part of the work of the Inspectorate therefore lies in the professional development of all of its staff. The people we were inspecting deserved to be confident that the people inspecting them were experts at their job.

19. When a new HMI was appointed, the first six months at least were largely induction. New inspectors were given experience in a wide range of different settings.

### **Role of HMI and HMIE**

20. Inspectors in Scotland are given powers under the 1980 Education (Scotland) Act. However, the Inspectorate in Scotland is an organisational construct; organisational matters are dealt with administratively and not by legislation. That has always been the case in Scotland and is very unlike the equivalents in England and Wales, where there is direct legislation governing the office of the Chief Inspector. At one time I think there were over one hundred HMI involved in the organisation as a whole. Full-time inspectors were complemented by a large number of 'Associate Assessors' who were practising teachers (often headteachers) and 'Lay' members of inspection teams drawn from the wider public. The way in which staff were organised and deployed were decisions of the senior team, commensurate with the needs of the time.
21. HMIE was and is not a regulatory body. HMIE has no direct powers at its own hand; it does not have the direct power to command or punish, nor does it investigate individual cases. HMIE's task is essentially to identify strengths and weaknesses in provision, advise and recommend on practice that will maximise quality in whatever setting is being looked at and to provide general advice and guidance to professionals and policy makers. Its main focus is on the educational experience and welfare of children, young people and adult learners in Scotland. The power of an inspection comes from the credibility of its staff, the integrity of the inspection process and the transparency of its findings.
22. Following problems with school examinations undertaken by the Scottish Qualifications Authority (SQA) in 2000 there was a review of the organisational role of HM Inspectorate within Scottish education. Hitherto, the Inspectorate had been located within the education department of the Scottish Executive but it was agreed that it would be better for it to become an Executive Agency. That new status further enshrined the independence of HM Inspectorate and gave it more operational freedom.

23. The Executive Agency was created in 2001 and I took over as HMSCI and accountable officer in 2002. It was an enormous change that provided significant autonomy and operational freedom. As accountable officer I was ultimately responsible for decisions as to how best to deploy the organisation's budget. I increased the administrative side of the organisation, a lot of which had previously been carried out by Inspectors. Doing so then released the Inspectors to do more of the frontline educational work for which they were appointed.
24. A framework document for HMIE as a new Agency was agreed with Scottish Ministers, which enshrined the independence of the Inspectorate and also gave me direct access to the Education Minister, without having to go through civil servants. There were many meetings with Ministers and officials to provide professional advice, drawing on the extensive evidence garnered from inspection.
25. No longer being part of the Education Department meant that we had to redefine the nature of the relationship between the work of the Inspectorate and the core civil service and we found a way of working that suited those new arrangements.

### **Developing Inspection Practice**

26. As in all of our work inspecting schools and other educational settings, we had a significant and established role in evaluating the quality of relationships, culture, wellbeing and welfare. The Scottish Commission for the Regulation of Care (called the Care Commission) had been created around 2000 and throughout my time as HMSCI, a shift was taking place nationally leading to a stronger focus on safeguarding and the importance of ensuring that young people's welfare and wellbeing was a central part of the work of schools and residential settings. We worked closely with the Care Commission, agreeing joint approaches to inspection and publishing joint reports.
27. Legislation relating to safeguarding had implications for the work of the Inspectorate. We were consulted on these implications and were also represented on committees and working parties including, for example, one on care standards. Prior to 2001,

inspection activity in relation to secure care settings was coordinated by an inspector with relevant expertise who drew together the work of a team of inspectors with individual remits to look at specific areas of work.

28. The Inspectorate did not have a direct role in relation to investigating individual children and cases. However, we would follow up to evaluate how far appropriate action had been taken to prevent further problems. One of the central ways in which inspections are carried out is that the Inspectors will always engage with the children, whatever the setting. There would always be discussions with young people as part of the process of an inspection.
29. An inspection is based on gathering first-hand evidence of what is actually happening in a particular setting. That evidence is then used in order to give our view on the extent to which what has been seen is appropriate for young people to experience and is likely to give the kind of quality of education that is required. When anything came to our attention which gave concern in relation to safeguarding, we would immediately raise that with whatever body would be most appropriate – for example the relevant social work department.
30. In the early part of this century there were a number of very distressing cases of child abuse, both north and south of the border, which led to a focus on issues in relation to child protection and safeguarding. That focus became increasingly robust and we had Ministers who were very committed and very interested in ensuring that both the education and the welfare of young people was properly looked after.
31. During my time as HMSCI, the prime responsibility for the regulation of secure care and other residential special and boarding settings lay with the recently created Care Commission. We participated with them in joint inspections, where we were evaluating the quality of the education that the young people were receiving while also contributing to a view about culture and relationships. One of the consistent issues that had been around for some time and one that was becoming increasingly more evident in the early part of this century was the extent to which information about individuals was not being automatically shared across relevant bodies. The various

bodies that had a role in relation to safeguarding were not necessarily communicating very well with each other and the opportunity to identify early any issues of concern was too often being missed.

32. Accordingly, in that period between 2003 and 2004, I was asked by the First Minister to set up and lead a team that would systematically look at each local authority area with regard to how effective its child protection procedures were. There was to be a particular focus on all of the organisations involved and whether they were working well together and making recommendations relating to areas where they were not.
33. In order to take that forward, a multi-disciplinary team was formed within HMIE and I appointed staff specifically for that purpose. The team, in addition to my own staff, consisted of police officers, social work staff and medical staff, all seconded into the organisation. They had responsibility for looking not just at the local authority, but also at all the organisations that were responsible in the broadest terms for safeguarding.
34. Neil McKechnie was appointed to my senior team at the time the multi-disciplinary inspections were established and had overall responsibility for this within the Inspectorate. He came from West Dunbartonshire where he had been a senior local authority officer.
35. Every local authority area was inspected over a three year period and ultimately a report was produced with the generalised findings and recommendations for child protection in each area. A second cycle went on beyond my time as head of the Inspectorate.
36. The general approach that HMI were using in fulfilling our responsibilities was, in addition to evaluating practice, to promote self-evaluation amongst the bodies that were in the frontline. Those bodies ought themselves to have evaluation procedures in place that allowed them to identify issues early, rather than waiting for an external body to come in. We produced a series of publications called 'How good is our school', which used a six-point scale to rate different aspects of a school's work and that characterised school inspections from the late 1990s. Those publications were



intended to be used both by Inspectors and by those who were being inspected as a 'common language' about quality and outcomes.

37. We applied the same principle in relation to the child protection inspections of the local authorities and we developed a system of quality indicators based on child protection standards. Part of the process was to make recommendations about ongoing self-evaluation beyond our inspection.
38. It was clear right at the outset that if we were to do this well, we were going to require access to confidential records and that required legislation. Accordingly, legislation was introduced in 2005 to permit this and at the start of each multi-disciplinary inspection a number of case records were selected and looked at in detail. Thereafter, the inspection moved out to the broader procedures that operated in the area, both with the local authority and with the various organisations involved.
39. It was very thorough and systematic and was not always an easy process. Some inspections had big implications for the staff involved in the process inside the local authorities and other relevant organisations. At the conclusion of each inspection, reports were produced with recommendations.
40. It was a very high-profile and important process and when I look back on my career it is one of the areas in which I have the greatest pride. I am proud of the extent to which we were able to establish that process, to carry it forward and to maintain high credibility.
41. Specifically in relation to the inspection of secure care settings, the Care Commission were in the lead and we staffed the inspection jointly with them to look at the educational provision and contribute to wider considerations about welfare and safeguarding. We also worked with the Inspectorate of Prisons (HMIP) and, at the request of HMIP, I provided appropriate members of staff to join their team when inspections were taking place in those institutions.

## **Policies**

42. There are inspection guidelines specific to each sector we inspected, including separate guidelines for residential and secure care settings. While I was not involved in the specifics of those policies and I do not have detailed knowledge of them, my concern was that appropriate guidelines were in place.
  
43. In my early years with the Inspectorate, child protection did not have as high a profile as more recently. However, matters relating to the welfare of young people were integral to all inspections. Culture and welfare were included in the quality indicators used in inspections and for self-evaluation. We introduced unannounced 'Care and Welfare' inspections designed to identify school cultures and practices that might cause concern or suggest best practice. I remember an inspection of this type in Musselburgh Grammar School in 1999 that highlighted significant issues relating to culture and safety. The inspection report received a lot of media attention and led to important improvements in practice. When I took over as HMSCI I was very keen that the Inspectorate should be active in the area of child protection and the process over the period from the late 1990s to when I retired was one of increasing focus and increasing rigour in that regard.
  
44. With the work of the multi-disciplinary teams, the Inspectorate had involvement in the development of policies relating to the safeguarding and protection of children as well as the provision of education to children. I do not have detailed knowledge of that involvement.
  
45. My involvement was more strategic, but one of my former colleagues, Alistair Marquis, did a lot of work developing written child protection guidelines for the Inspectorate internally. These guidelines gave inspectors clear guidance about the steps to be followed if a child disclosed abuse or if they had concerns that abuse might be taking place. Alistair was a former primary school head teacher and came into the Inspectorate as primary Inspector and then became an Assistant Chief Inspector.

46. It is obviously crucial that there is no question that Inspectors, who have privileged access, must operate in a way that observes safeguarding procedures. The Inspectors themselves have to observe appropriate child protection procedures, such as not being alone with young people and leaving doors open when they are speaking to them. A pocket card was issued to all inspectors with relevant advice. Another former colleague, Marjorie Browning, was very heavily involved and very committed to that work, but she unfortunately has died.
47. The Inspectorate were partly responding and partly leading on thinking through how we could evaluate the safety and well-being of young people in secure care settings. Guidelines were published in 2005 and in 2009 called 'How well are children protected and their needs met?' and a further report, whose title I cannot recall, was also published by the Inspectorate in 2008 or 2009.
48. In the early inspections I was involved in, an inspection of a secondary school could have had more than twenty Inspectors involved, it could last a period of months and it would produce a lengthy report, which was very detailed and broadly-based. The number of inspections would be determined by how many could be done with the allocated resources. There was no expectation regarding frequency, so a secondary school for example could be inspected as infrequently as once every twenty years.
49. There was also no public accountability role prior to 1983 in relation to individual schools. The role of the Inspectorate before then was very much to use the inspection of schools partly for individual inspectors to offer advice and partly, in order to fulfil the Inspectorate's role inside the Scottish Education Department, to provide professional advice to Ministers, civil servants and local managers. Professional discussions with local authority staff and schools were an integral part of the work of HMI but these discussions did not lead to published reports. However, the Inspectorate did draw on its evidence to produce more general thematic advice in the form of published reports. HMI were also represented as assessors on all key working parties and committees. The CCC, for example, had direct involvement of HMI on its working groups. The Inspectorate was also directly involved in supporting and sometimes leading major

national developments such as the introduction of Standard Grade qualifications in the 1980s.

50. 1983 was a pivotal year because prior to then reports on inspections were not published. However, thereafter the government decided that reports on schools had to be published throughout the United Kingdom. Consequently, inspection reports were printed and given to the school for distribution to parents and additionally were made available to the press.
51. As that process went on into the 1990s, there were discussions internally in which I was involved about the cycle of inspections. It was felt that we needed to have greater predictability about that cycle. The approach we adopted was to talk about a 'generational cycle', which meant that a school would be inspected broadly within the lifetime of any one pupil within that school. Therefore it would be a seven-year cycle for a primary school and a six-year cycle for a secondary school, albeit not all children stayed on for six years. Recommendations would then be made and there would be a follow up inspection a year later and we would publish a report detailing how well a school had taken forward our recommendations.
52. That generational cycle came in towards the end of the 1990s, about when I became Depute Senior Chief. In order to achieve that cycle we had to be very clear about what the essence of an inspection should be and what we should report on. The size of teams and the length of time an inspection took was compressed to try and produce a report that, at the end of the day, focussed on what was most important.
53. The report was to inform parents and be more accessible and it was subject to plain English guidelines. Considerable attention was given to making reports accessible to a non-professional readership. Also, particularly as we got into the period of the early part of this century, more had to be done to ensure that children were safe in whatever setting they were being educated.
54. The nature of what was inspected became more targeted, the inspection process became more truncated and reports became shorter. Every year we employed an

independent company to go back to a sample of schools we had inspected to give us information about how the school had reacted to the recommendations and how the parents had reacted. Based on that we were able to refine the nature of what we did as an Inspectorate.

55. There were, however, complaints from local authorities and teacher unions about the burden of inspection and regulation generally. Mainly in response to that, the Government set up a review of regulation, audit and inspection which was undertaken by a lawyer, Lorne Crerar, and which reported in 2007. The thrust of the Crerar Review was to reduce the number of separate and sometimes overlapping inspections and he made a number of recommendations.
56. The way in which HMI went about the work in Scotland was to try and strike a balance between accountability and improvement. What we tried to do was ensure that the inspection process not only reported on how well things were going, but we also wanted to encourage improvement. Encouraging improvement could be achieved both through the standard inspection process and through the many thematic inspections we undertook in addition.
57. The thematic inspections looked at the issues of the day and we then produced a thematic report. A thematic inspection did not relate to one particular establishment, but used the inspection of lots of establishments in order to make a general report on a particular area and make recommendations to Government about how things should move forward. I cannot remember the details but I think that safeguarding was included in such reports.
58. I was concerned that the result of the Crerar Review might mean we would lose that sort of improvement role and become too focussed on producing fairly generic evaluation reports. The very important role of the interaction between an Inspector and those who were being inspected, could and should itself lead to improvements in practice. With the independence that I had, I took the view that if I had a hundred highly qualified educators in Scotland working for me, I wanted to use that resource to do much more than just give assurance.

59. Ultimately, I think the Government broadly accepted my concerns although important changes were made, for example with more joint inspections involving more than one body such as joint work with Audit Scotland. However, over that whole period there was pressure to do less inspections while at the same time issues of welfare and safeguarding were gaining greater prominence. There was a constant tension as to how you balanced those two, while maintaining the integrity of the inspection and fulfilling the requirements to be as proportionate as possible in terms of the way in which the process was conducted.
60. I felt there wasn't enough of a focus on those children experiencing various forms of disadvantage, which is possibly a reflection of the start of my teaching in a school where I saw first-hand the challenges that were facing these young people. In 2002, shortly after I started in the role of HMSCI, we introduced a series of thematic reports called 'Count us in', which was intended to focus on those young people who often don't receive the same attention other youngsters get. Quite deliberately over my time as head of the Inspectorate I was very keen to maintain a focus on young people who could be inside or outside mainstream school education, including those in residential and secure care settings.
61. In 2004 and 2005, the process of inspection became even more concerned with ensuring issues of safeguarding and the welfare of young people. National policy was focusing on issues of cooperation and coordination and a policy called 'Getting it right for every child' was introduced, which considered every child, particularly vulnerable young people, and focused on much better joint working across agencies..
62. While the Inspectorate published thematic reports, we hadn't drawn together evidence from all of our inspections to give an overview on education in the entire nation. I introduced what was called 'Improving Scottish Education' and, during my time, two such reports were produced, one from 2002 to 2005 and another from 2005 to 2008.
63. The latter report has a specific section on child protection services in local authority areas, drawing on the inspection work that the multi-disciplinary teams were doing.

That section of the report charted our findings from the inspections across all the local authorities to give a broader picture of child protection.

### **Inspections**

64. There were inspection guidelines relating to the process of inspection of establishments such as List D Schools, residential schools, assessment centres, remand centres, secure units and Young Offenders Institutions so far as the safeguarding and protection of children and the provision of education to children were concerned. Prior to the establishment of the Care Commission, Social Work Services Inspectorate had a role in relation to the inspection of such establishments.
65. The Care Commission has legislative responsibilities in relation to safeguarding. While our contribution was mainly in relation to the educational provision, we remained involved in evaluating general issues of care and welfare. The guidelines were clear with regard to how HMI should go about the nature of each inspection.
66. The joint inspection evaluated an establishment's approach to education, safeguarding and child protection using quality indicators. HMI would participate in the discussions at the end as part of the team along with the Care Commission and reports were jointly badged.
67. The frequency of these inspections was a legislative requirement of the Care Commission; as far as I can recall in some cases it was twice a year. Separately, however, there was the issue of how often should HMI inspect educational provision which was less subject to such fast change.
68. An inspection team would include Care Commission staff, assisted by HMI who were focussing on education, but in so doing would also be alert to issues to do with wellbeing and safeguarding. The team would operate jointly and would talk to each other about issues that were emerging.

69. This was not an area I was really involved in directly throughout my Inspectorate career. The only occasions I remember was the inspection of a couple of List D schools and a couple of secure units. I was not running those inspections, but I was mainly looking at the provision of social studies in the List D schools and the educational provision in the secure units. I did, however, visit settings during inspections as part of my leadership responsibilities following promotion.
70. I do not remember what notice was given to these establishments prior to inspection. I cannot remember the exact details, but we did introduce a small number of unannounced inspections, which were primarily focussed on care and welfare. They were very controversial and there was a lot of anxiety about them. At the same time, there was also quite strong support for unannounced inspection from both teachers and the wider public.
71. I don't think that there were usually particular triggers for unannounced inspections. In the main they were deliberately random but informed by local evidence. I suppose, in addition to seeing schools without time to prepare, part of the logic was to concentrate minds: you shouldn't assume, if you had just been inspected as part of a cycle, that you could relax for another few years. We didn't do very many of them, but they were designed to make a point that anyone could be inspected at any time and that the care and welfare of young people should not require any preparation.
72. Inspection is only as powerful as it is credible and the credibility come from each individual HMI. Significant investment in the training of Inspectors and consistency of judgement is very important. I was very clear that we needed to preserve a significant number of days for every Inspector to engage in training and professional development.
73. Inspectors have to be up to date with best practice and changes in education policy and must be given time for that. The principle with regard to the training of Inspectors was that an Inspector had a two-hundred-and-twenty day working year and within that could be deployed on frontline inspection for up to one-hundred and twenty days. We always had a protected quantum of time for training and professional development,



which could be around ten days. The allocation could be slightly more or slightly less if, for example, major changes were being introduced.

74. There were annual inspectorate conferences where everybody came together and major issues were dealt with. Each of the Directorates, or areas of functional responsibility, would also have conferences of staff.
75. During my time as HMSCI, the Inspectorate scored consistently highly in the annual civil service staff survey, particularly in relation to the belief of staff in the worth of their work. Professional development is one of the most important ways of continuing to give staff the confidence that they are well prepared in a very changing environment.
76. Whatever the setting, inspection is evidence-led. That evidence stems from: documentation; analysis of attainment and other relevant data; questionnaires that go to parents, pupils and staff; direct observation learning and teaching; analysis of examples of pupils' work; and interviews with staff and with pupils, the latter usually selected at random.
77. Observation and discussion with pupils is a critical part of the process. In addition to discussions in class, the pupils would usually bring their workbooks along to separate interviews and the inspector would have a discussion with them about the work they were doing. Normally the Inspector would be in the room on their own with the pupil but the door would be open in line with our guidelines.
78. The inspection would be interested in the school's policy documents, access to relevant records and local authority policies in relation to the setting, or if it was independent, whatever their particular policies were. Any relevant documentation which governed the work of the setting would be of interest.
79. The inspector might go round the school, normally with the head, on what came to be called 'Learning walks', and the head would talk about what was happening in each particular room. That would provide an opportunity to see the school at work, assess relationships and learn how well a head knew their own school.

80. A whole range of techniques were used, all designed to triangulate evidence. The approach was to get evidence from different sources and crosscheck to gradually build up as accurate a picture as possible. At the end of each day the Reporting Officer would have regular discussions with the headteacher. Such discussions gave schools the opportunity to highlight areas that they saw as relevant but which the team may not have come across. The school would be given every opportunity to tell us about their strengths or about areas they would like feedback on.
81. The questionnaires that went to parents, pupils and staff included a series of questions, together with any general comments they might make. They went to parents or carers of children in residential and secure settings as well. Latterly, these questionnaires specifically asked of parents whether they felt their children were safe at school. The pupils were asked the same questions, which was designed to alert the team to anything they needed to follow through. Specific disclosures could be made as part of that process, albeit I'm not personally aware of any.
82. The return on those questionnaires was generally modest and varied with the nature of the catchment area. The school issued them and sometimes the degree of urgency the school attached to the request to respond could influence the response rate. An interesting dimension was how those questionnaires were interpreted because, by and large, they tended to give a favourable impression of the school. If any questions dropped below a positive threshold then that was an indication that further evidence should be sought.
83. Direct observation of learning was absolutely central to the process. Inspectors would sit in classes, walk around asking children what they were doing and talk to the teacher and ask what they were trying to achieve in the course of a particular lesson. It was not the observation of the teacher as a performer, it was the observation of the nature of the learning that was taking place inside that classroom and the overall climate of relationships; whether children were being appropriately challenged, whether there were youngsters that were disengaged from the learning and whether the general ethos was positive.

84. The inspector wanted to establish what each classroom was like as a learning and social environment, how challenging it was, how differing attention levels were accounted for and how aware the teacher was of prerequisite learning. A lesson would not be rated, although that had been done for a short time until we stopped it. You were forming a general view of a school and if individual issues emerged you would talk to the headteacher and they would deal with them separately. The purpose of an inspection was not to focus only on specifics but to use a wide range of evidence to come up with an overview and to make recommendations for improvement.
85. Leadership was a big focus of 'How good is our school' and, during my time in HM Inspectorate, an emphasis on management developed into a broader conception of leadership. Through the period from the early to mid-1990s onwards the focus on leadership increased dramatically.
86. An important part of what was looked at was an evaluation of the establishments' policies, practices and guidance regarding child protection, their complaints procedure, the discipline and punishment of children, the process for dealing with complaints and allegations against staff, whistleblowing and record-keeping. Particularly as we moved forward in this period that focus became much greater. Normally a school would use local authority policies and the inspection team would look at how they were being interpreted and applied. We would expect an independent setting to have their own suite of policies that we would similarly evaluate.
87. All of those methods employed would be used in order to arrive at a view. If you were talking about child protection policies you would ask the Head being interviewed to give an example and explain how it worked and what the outcome was. Where there were significant issues, these would be made clear and associated action expected.
88. There is a three-stage process at the end of an inspection. First of all there is oral feedback during a formal session with the management team of the school or establishment, at which time they can comment. They then receive a draft of the full report which, at that stage, is supposed to be for factual accuracy, although they can

comment on the draft. Some take the opportunity to provide more information and so there are two stages in which the establishment can challenge or introduce fresh evidence. Lastly there is the final, published report.

89. The message to inspectors is that there should be no surprises. In the course of the inspection itself there ought to have been sufficient contact with the team for the school to realise broadly what was coming at the oral feedback stage at the end. Each day, they should have regular discussions with the headteacher and build up an ongoing dialogue.
90. There should also not be any surprises when the establishment gets the draft report. Once the inspectors have fed back they should make sure the draft report does not introduce something they have not already raised.
91. The process of reporting any concerns about safeguarding, child protection or the provision of education on inspection would depend on the nature of any concern. Such concerns could, depending on their nature, first of all go to the head of the establishment and, if it was serious enough and it was a local authority establishment we would draw it to the attention of the authority and social work. At an independent establishment we would again go to the head and draw it to the attention of social work. If it was very serious we would contact the police. For example, in 2003 (I think) we were concerned about a number of serious issues, including disciplinary practices, in an independent Muslim school in Glasgow. As a result the school closed.
92. Essentially, if something worrying is identified it has to be referred on. Nothing should be ignored, everything must be dealt with. The Reporting Officer and colleagues would have a discussion about how the concern ought to be dealt with and senior inspectors would often be brought in at that stage to agree what course of action should be taken.
93. We would tend not to pursue ourselves specific concerns about individuals that might have been raised. That is not the role of the Inspectorate, however we would reflect back and consider whether the concern was a worrying example of something that

was systemic, or was an exception that was not indicative of the way in which the school operated.

94. If any concerns about an establishment's policies on child protection or safeguarding found their way into a recommendation we would follow up within a year and see whether or not that recommendation had been acted upon and a report would be published to that effect.

### **Record keeping**

95. If the focus of an inspection was child protection, records of the children in the care of an establishment would be examined. In the multi-disciplinary inspections individual records were looked at and trails were followed in relation to the actions taken, but that kind of issue would tend to fall more to the Care Commission.
96. The Care Commission would primarily look at an establishment's policies on record-keeping and record-keeping in practice. There would also be a focus on the quality of the records as a source of information, including the information kept after any allegation of abuse, ill-treatment or inappropriate conduct had been made by, or on behalf of, a child. In practice, there would be interchange between the team on such matters.

### **Concerns about establishments**

97. In my various roles in the Inspectorate I did not personally identify specific examples of serious concerns about the way in which individual children and young people in establishments such as List D Schools, residential schools, assessment centres, remand centres, secure units and Young Offenders Institutions were treated. There were of course many instances of such concerns being identified by colleagues, but I was involved in very few secure care establishment inspections as part of my career.
98. What I, or any of my staff, would be concerned about was whether or not they were getting access to a broad and challenging enough educational base and whether the

culture and relationships in a school were positive. The welfare of the young people would always be at the heart of an inspection. The temptation can be to do the things that keep troubled children passive, but not to actually pursue the broad and stimulating education that all young people are entitled to. That would not be the norm but would be specific to a particular establishment.

99. A decision would be taken on each case as to whether the parents of the children were made aware of any concerns about how their children were being treated. The strength and balance of the issues would dictate the result of that decision, however, in principle the presumption should be that anything of significance would lead to the parents or carers being involved.

100. The likelihood of any inspection by HMI or HMIE uncovering the abuse or ill-treatment of an individual child in such establishments at or around the time it was occurring would be very dependent on disclosure, either through the questionnaires or through the work of the team. However, inspectors were very focused on the welfare of young people and, while such concerns may not come at us directly, we would always be alert to issues of safeguarding and welfare.

101. In 1994, as Chief Inspector of Northern Division, I oversaw an inspection of a residential school on the Black Isle called Raddery.

Secondary Institutions - to be published later

Secondary Institutions - to be published later

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Secondary Institutions - to be published later

104. Unusually as Chief Inspector of Northern Division, I personally participated in the inspection of the school, which took two or three months to complete. It was very obvious where the points of risk were and ultimately we made a variety of recommendations to do with young people having private access to 'Childline', ensuring that both male and female staff were on at night and ensuring that only female staff went into girls' bedrooms and dormitories.

105.

Secondary Institutions - to be published later

Secondary Institutions - to be published later

We published a report including our recommendations and all were acted upon by the school. Our work in the Raddery example illustrates our role, not as investigators of individual cases or even regulators but as independent professionals charged with advising on the ways in which issues associated with safeguarding can be addressed proactively.

106. Another unusual example related to the Dungavel Immigration Removal Centre where, in 2003 I think, HMIP England and Wales were concerned about the welfare of and provision for children who could be held there for some considerable length of time. We were invited by HMIP to undertake a follow-up to their visit and delivered a report that led to significant changes in practice.

107. I can't remember the specifics, but in the course of the inspections carried out by the multi-disciplinary teams, there were occasions when looking at the records gave the team cause for concern. The inspection couldn't continue without those concerns being dealt with and they were then taken forward in whatever way was most appropriate.

### **Discipline and punishment of children**

108. If there were any concerns about the discipline and punishment of children at establishments such as List D Schools, residential schools, assessment centres, remand centres, secure units and Young Offenders Institutions they would have been dealt with according to our guidelines. I was not directly involved in an inspection that found any significant issues of that nature. If any Inspector did have any such concerns I would expect them to be raised and dealt with immediately.

### **Reporting of complaints/concerns during your roles with HMI and HMIE**

109. Our expectations when inspecting any educational establishment would be that the mechanisms by which a young person could express a concern were in place inside that establishment. We would expect, for example, that Childline posters would be up in corridors and in toilets and that there was a phone that was accessible by children without having to go through a member of staff.

### **'Abuse'**

110. The definition of abuse would be covered by the quality indicators and the standards and would be included in the training that was undertaken by Inspectors. Alistair Marquis would be better able to explain how that definition applied to the treatment of children at secure care types of establishments.

### **Child protection arrangements**

111. Child protection arrangements and how staff within secure care establishments were given guidance and instruction in relation to child protection would certainly be a focus of an inspection. I do not have any direct knowledge of the specifics. The experts within the Inspectorate would deal with the guidance and instruction that was given to staff of such establishments.

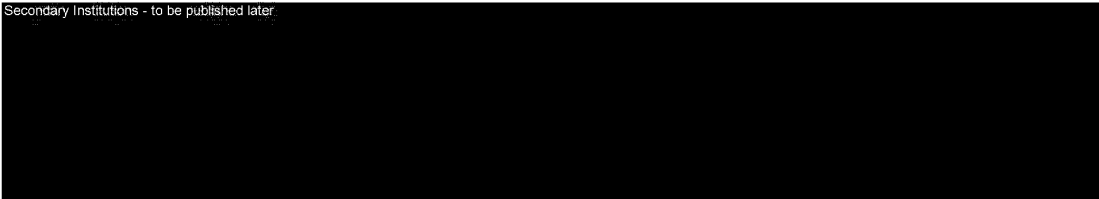


112. At a very general level, the care standards and the expectations on safeguarding and the child protection arrangements that were in place would be looked directly at by the Care Commission Inspectors.

**Investigations into abuse – personal involvement**

113. The Inspectorate would not be directly involved in investigations into abuse. The

Secondary Institutions - to be published later



114. The multi-disciplinary inspections did look at case studies, which may have detailed the nature of allegations and how matters were dealt with and reported on thereafter, but I have no knowledge of specific cases. Such matters would be taken forward by colleagues with relevant expertise in the area.

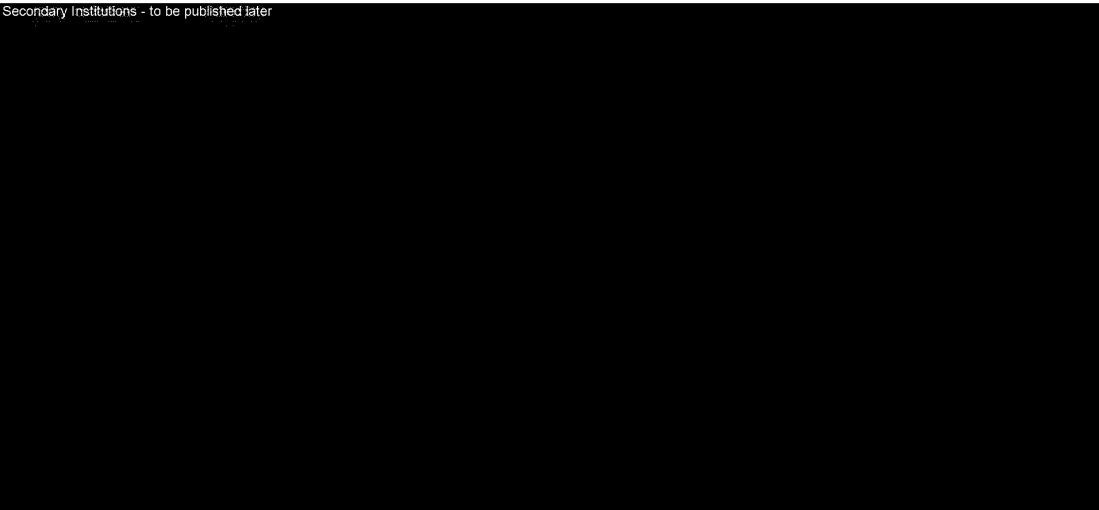
115. There were occasions when we, the Inspectorate, had concerns about schools, not because there had been allegations of abuse, but because evidence gathered during an inspection gave cause for such concern.

Secondary Institutions - to be published later



116.

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117.

### Reports of abuse and civil claims

118. I was never involved in the handling of reports to, or civil claims made against, any secure care establishments by former residents, concerning historical abuse.

### Police investigations/criminal proceedings

119. Secondary Institutions - to be published later

120. I have never given a statement to the police or the Crown concerning alleged abuse of children cared for at any secure care establishment and I have never given evidence at a trial.

### Convicted abusers

121. Secondary Institutions - to be published later  
I am not aware of any other person at any other establishment having been convicted of the abuse of a child or children. Secondary Institutions - to be published later

Secondary Institutions - to be published later  
122. Secondary Institutions - to be published later

### Helping the Inquiry

123. I was, for a time, president of the Standing International Conference of Inspectorates (SICI), which started in 1996, I think, with five or six of the long-established Inspectorates in Europe. Inspectorates from Scotland, England, France, the Czech Republic, Sweden and possibly Wales, met together once or twice a year to exchange

intelligence and experience about inspection practice. Over the period from then to when I retired from the Inspectorate in 2010 the number of Inspectorates involved rose to thirty.

124. At these meetings, one of the Inspectorates would lead a training session on a particular topic they either felt strong in, or that they wanted to bring people together to discuss. Inspectorates could exchange experiences and views and participate in specific training. SICI is still in existence and was a very helpful forum. I cannot recall all that we did at the various conferences I attended, although details may be on the SICI website, however I do believe there were discussions about care and welfare of various settings, which may be of interest to the Inquiry.
125. A major piece of research was carried out by Professor Melanie Ehren around 2007, I think, who looked across Inspectorates throughout Europe. The Inquiry may find her insights useful.
126. The educational attainment of young people within secure care settings would certainly be a focus of an inspection, however such schools do not have the numbers of young people to be able to undertake reliably a comparative analysis. A judgement regarding educational attainment at such settings would tend to be based on the inspectors' interaction with the young people being educated there. Inspectors would look at the experience of the young people within the setting, the pathways that they were able to pursue, what routes were open to them in moving through and beyond the school, rather than the comparative metrics that were used in mainstream schools.
127. The Inspectorate would have wanted to see a more consistent focus on education for young people in secure care establishments. In principle, the Inspectorate would look to ensure that a young person's life chances and the pathways open to them were appropriate, despite the fact that they had not been given access to the breadth of education that a child in a mainstream establishment would have. We know that young people in care settings of a whole variety of kinds can fail to get the opportunities that they should. We would address any particular concerns in that regard through the inspection of such establishments.

128. It would be extremely difficult for me to comment as to how inspection arrangements in Scotland today could be improved so as to better protect children in such establishments from abuse as things have moved on since I retired from the Inspectorate. In general, we need to have regular engagement by an outside body with those schools so that the opportunity for an external perspective can be brought to bear on the establishment, including on a cyclical basis.
129. Lorne Crerar talked about getting rid of cyclical inspections and I think that was wrong. I didn't agree and I don't agree with the view that inspection is a burden. I think inspection done badly is a burden but good inspection should work with staff, parents/carers and the young people themselves to improve a school. Good head teachers often said that they have been provided with access to the most incredible free consultancy. Inspection should be welcomed by schools as a means of affirming what they do well and helping to identify areas for improvement. That external view by inspectors should be combined with a school's own self-evaluation in order to get a picture of how well it is serving its young people and to help identify priorities for improvement.
130. A focus on self-evaluation and on creating a common understanding about what quality looks like should mitigate the risk that everyone involved may be using the same words but meaning different things. We need common points of reference with regard to quality and improvement. All of that is a very important part of the picture with regard to the protection of children in establishments such as residential schools, assessment centres, remand centres, secure units and Young Offenders Institutions, now and in the future.
131. In any given context, being able to combine a school that has been systematic, reflective and open in its own self-evaluation with an external perspective, means that you are likely to get something that is closer to the reality of how things are operating for young people in that setting. Good inspection is preventative and pre-emptive. However, ultimately external inspection can provide no guarantees. At its best, it can

help to stop things going wrong, rather than telling you afterwards that they have already gone wrong.

- 132. In my view, the key role of inspection is that it is an early warning system where culture, practice and procedures are not in line with best practice. It can help to head things off that might otherwise have gone wrong. At the same time, it provides necessary public assurance about the quality of the educational experience of our young people, not least in relation to their wellbeing.

**Other information**

- 133. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true to the best of my recollection.

Signed.....  
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Dated.....  
11 January 2023