Tuesday, 30 May 2023

(10.00 am)

LADY SMITH: Good morning. Welcome to the second week of our expert evidence. We move today, as I think was indicated last week, to hear Professor Levitt, who is going to cover inspections today and tomorrow, I understand, and is here and ready to give evidence.

Mr MacAulay.

MR MACAULAY: Yes, my Lady. That is the position. Can I make it clear that today I'll be looking at the inspection report that covers the period 1992 to 2005. Tomorrow, I'll look at the final inspection.

LADY SMITH: Thank you very much.

MR MACAULAY: I would recall Professor Levitt.

LADY SMITH: Thank you.

Professor Ian Levitt (re-called)

LADY SMITH: Good morning, Professor Levitt. Welcome back. Could you take the oath, please, by raising your right hand.

Professor Ian Levitt (re-sworn)

LADY SMITH: Do sit down and make yourself comfortable.

Professor Levitt, you've been here before at our other building, you know how we work and what to expect, I hope. But be assured I never forget that it's hard work giving evidence and can be very anxious-making.

I normally take a break at about 11.30 in the morning and in the middle of the afternoon session as well. But, if you want a break at any other time, please do say. As ever, if we're not making sense in any questions we ask you that's our fault not yours, so don't hesitate to speak up; okay?

A. Thank you, my Lady.

LADY SMITH: If you're ready, I'll hand over to Mr MacAulay and we'll take it from there.

MR MACAULAY: My Lady, thank you.

Good morning, Professor Levitt. This is your fifth visit I think, having been here on 2 November and 3 November 2017 and 4 April and 10 April 2019.

And you are here today to talk to your inspection report covering the period 1992 to 2005?

A. Yes.

Q. I think tomorrow we'll look at your final inspection report.

Can I take it that there is no change to your CV from when you were here before?

A. I think I've updated it. I handed it in to the office.

Q. So what have you included that we hadn't looked at before?

A. I think the previous was an abridged one. This is completely unabridged, from whenever I began in

academia.
Q. And I think that's the one I have in front of me, that sets out articles and chapters and books and so on?
A. That's right, yes.
LADY SMITH: Mr MacAulay, I'm sorry to interrupt, could I just ask the stenographers what to do, because I'm not seeing the transcript coming up on my screen. My last option is Day 349, which of course is last week.
(10.33 am)
LADY SMITH: Thank you.
I'm so sorry about that delay, Professor Levitt, but I need to see the transcript appearing in front of me, and also be assured that it is transmitting to our system. But it's obviously doing that now.
Mr MacAulay.
MR MACAULAY: My Lady, before I start, the planned break was for 11.30 --
LADY SMITH: We'll --
MR MACAULAY: -- I wonder whether it should be put back to 11.45.
LADY SMITH: 11.45 would work well, yes.
MR MACAULAY: That would suit me.
Professor Levitt, you will see on the screen that the report I'm going to be looking at today -- and that's at SGV-000083601, and I think you have your own

hard copy in front of you?

A. Yes.

Q. You can either use the screen or the hard copy.

A. Yes.

Q. Just to backtrack a little bit, the last time you were here, you looked at the period from 1969 to 1992, and you're going to continue from there on, today.

A. Yes.

Q. That was a period that post-dated the Social Work Act 1968.

A. That's correct, yes.

Q. I think you told us that the Social Work Services Group was formed in 1967 to assume functions previously exercised in both the Scottish Home and Health department and the Scottish Education Department?

A. That's correct, yes.

Q. And also to prepare the groundwork for the 1968 Act?

A. The ground work for its implementation.

Q. Yes.

You also told us that the Central Advisory Service, CAS, was established in about 1968?

A. It was established in March 1968.

Q. Its functions included advising the Secretary of State and inspectorial functions, including reviews of deaths in care?

A. That's correct, yes.
Q. Just to recap on this particular point, the 1968 Act devolved the registration of residential homes to Local Authorities?
A. That's correct, yes.
Q. And hence the inspection regimes of such homes fell on Local Authorities?
A. That was an interpretation of the Act that Social Work Services Group accepted, which I think is in the second report.
Q. Yes.

Now, looking at this first report for today, the 1992 to 2005 report, you set out your methodology and how you accessed the relevant materials. I think, in the main, it's similar to your previous approach?
A. That's correct. It was a combination of retained records at The National Archives of Scotland, plus some records retained by the Scottish Government which had not been, in effect, weeded ahead of transmission to The National Archives of Scotland.
Q. Can I then look at the first section in the report itself? That's on page 18. Can I just say the pagination for these purposes is the page number at the bottom right of the report.

Here you have a section headed:

"The administrative, legislative and regulatory background 1995."

As is, I think, your practice, you set out at the outset a summary of where you're going to go?

A. That's correct, yes.

Q. Can I take you to 1.1, "The legislative and administrative framework of inspection services"?

You tell us that in early March 1992 it was agreed that a Social Work Services Inspectorate would be established from 1 April.

A. That's correct, yes.

Q. Do you set out there what the function of this inspectorate was to be?

A. Yes. It's to evaluate reports on the quality of local social work services, assist the achievement of the national policy objectives, provide advice to the Secretary of State and provide guidance to local agencies on policy, implementation and practice.

Q. If we move on to paragraph 1.1.2, on page 19; do you tell us in that paragraph that the SWSI function was to include carrying out local social work services inspections?

A. It was to provide assistance to Local Authorities in delivering quality services across the board.

My, if you like, inferences that they were to

pressurise local services much more than they had in the previous period, but it wasn't necessarily to engage in inspecting the actual provision of services. They were to ensure that by conversation, by meetings, that the services would be improved rather than being inspected.

Q. Do I take from that they would engage with Local Authorities --

A. Yes.

Q. -- but not actually indulge in hands-on inspections of the services?

A. That's correct, yes.

Q. That is something that does come later?

A. Yes, yes.

Q. At 1.3, do you set out what the SWSI's legal powers of inspection were? And were they essentially the same as existed before?

A. They remained as they had been under CAS, following the 1968 Act.

LADY SMITH: Again, there's a power, but not a duty?

A. Sorry?

LADY SMITH: There's a power, but not a duty.

Sorry, Professor Levitt, you are probably hearing that as if --

A. Yes, it's a power, but it doesn't specify precisely what duties they should perform.

LADY SMITH: Yes.

MR MACAULAY: If you go on to page 20 of the report; do you, just below halfway, have a reference to what the Local Authority had been doing and, in particular, do we read there that Local Authority service inspectorates were set up on a proper arm's length basis?

A. That's correct.

Q. Can you just explain what that development meant?

A. The respective Local Authorities were in power to establish a unit within local government separate from the actual provision of social work services to inspect -- to assist the registration and inspect the quality of services provided in residential homes and other establishments.

Q. And the reference to "arm's length"; is that to indicate that they had a degree of independence in that job?

A. The intention was it would be independent of social work, local social work services who had established those services or who were commissioning those services.

Q. In this particular section, you also provide details of restructuring of functions within the Scottish Office. These are quite bewildering changes, but you set out, in particular at paragraph 1.1.9, what that restructuring meant.

A. Yes. It had nothing really to do with social work

services as such. It had to do -- my reading of it is a sort of cost-cutting exercise to reduce the number of departments in the then Scottish Office. And, basically, Scottish Education Department was united, I think, with the Industry Department and the Scottish Home and Health Department was similarly dissolved.

Q. At 1.1.11, you draw attention to an internal review into the arrangements for any investigations which the Secretary of State may feel it necessary to carry out into social work issues.

A. Yes.

Q. Can you just develop that for me? What did that involve?

A. What the ministers were being informed was the -- if you like, the statutory basis of the inspection service and the limitations of the information they could obtain when they conducted an inspection, if an inspection was so conducted. And it was clearly quite limited in terms of the information that they could actually obtain, at least directly.

Q. You set these limitations out on page 23?

A. Yes. They could examine the records, the registrar's files, but they were restricted in their exercise as to the extent of the records that they could actually review. It had to be directly related to the service

being provided.

Q. At paragraph 1.1.13, on page 24; do you set out another change that involved SWSG?

A. Yes. That was after the establishment of the Scottish Executive, a further revision occurred. In a sense, it was -- my assumption was it was unrelated to the issue, the direct issue of social work services, but the need really to divide Social Work Services Group into terms of the provision of childcare and provision of adult care and mental healthcare.

Q. Do we see now the emergence of the definition of "young people" and "looked-after children"? Which becomes relevant in particular when they are looking at deaths in care.

A. Without going into too much detail, what happened was that the officials who were responsible for childcare simply moved and were retitled Children's Services -- sorry, Young People and Looked-after Children's Services. So it was -- if one looks at the various handbooks of staff functions, it was the same officials; right? Except they were being renamed. And they were being separated from the overall Social Work Services Group, which had been dissolved.

It would appear confusing, but in fact it isn't confusing once you actually look at the duties being

performed. They continued with the duties that they were doing in terms of looked-after children, except they were not bound up within the Social Work Services Group, which contained the remit for mental health services and adult services.

Q. You then go on in the following section, at 1.2, to look at the position with regard to deaths of looked-after children. I think what you say is, from 1962, the Secretary of State required to be notified of any death of a child in residential homes or foster care?

A. Yes, that's correct. Yes.

Q. Can you just explain how the process worked?

A. The process was that within a specified time period the Local Authority or voluntary organisation would write to St Andrew's House or telephone St Andrew's House as well and inform them that the death of a child in care had occurred, and that then that would follow up with the papers relating to the death of that particular child.

It would then be -- the papers would then be reviewed within the Scottish Office in 1962, within the childcare division of the Scottish Office, later the Social Work Services Group, and then the children -- then the Looked-after Children Group, in 1999.

It would automatically be sent to one of the inspectors in 1992 and in 1999, one of the social work

inspectors, who would call on the services of the Department of Health medical officer, who then might call on the advice of HMI Inspector of Education. And there would be some correspondence between the officials and the Local Authority, or the voluntary body concerned, in terms of the death, and they might request further information on that death before closing the case, in terms of the interest of Scottish Ministers, previously the Secretary of State, or alternatively informing Scottish Ministers that there were serious concerns surrounding this particular death.

Q. And "looked after", as you set out on page 26, was intended to be a general term covering children accommodated by the authority?

A. That's correct, yes.

Q. So not just children in care, as we normally understand it, but also children perhaps residing at home under supervision?

A. Under supervision at home, yes.

I should also add that if you look at deaths in care in this period, what is perhaps quite important for the Inquiry is there would be an official letter from the Scottish Office to the Local Authority informing them that the case had been closed by the Secretary of State or Scottish Ministers. So it was quite a formal

process.

Q. At 1.2.10, on page 28, you make reference to an SWSG submission and you have quoted from that. For example:

"The expression 'looked after' will replace the existing term in care and will cover all children currently in care [as we discussed]."

Then you talk about the Local Authority forming a care plan.

A. That's one of the significant implications of the 1995 Children (Scotland) Act, that Local Authorities weren't simply to bring a child into care, but to develop a health, personal and educational plan for that particular child and to have that plan monitored.

Q. Yes. And who would monitor the plan?

A. The social workers who were assigned to that particular case.

Q. But, at this point in time, would there be any external monitoring by, for example, SWSI?

A. No, no, it was a devolved function on the Local Authorities and, obviously, the local social work services authorities.

So, in effect, it would be the professional social worker job to develop that plan, have it approved within the Local Authority and follow it through.

Q. Now, you move on in the next section, at 1.3, to look at

residential grant aided and independent schools, and you draw attention to the Education Scotland Act and what the provisions in relation to inspections were; can you just recap on that for me?

A. I think the 1980 Act restated earlier provisions and made it clear that all schools would be inspected by HMI education, and HM inspector of schools were part of the SED, Scottish Education Department and successor bodies, and that the inspections reports would be submitted in due course to the department of administrative officials, if there were any issues arising as a result of that inspection.

Q. At this time, under the 1980 Act, what would the HMI focus be in inspection?

A. Primarily on the provision of education.

Q. I think that changes as we move on.

A. Yes, that's correct. Yes.

Q. You also point out, at 1.3.2, that under the 1980 Act, the Secretary of State was also required to appoint a registrar of independent schools.

A. That's correct. This reflected earlier provision and the rules and regulations that followed that particular Act, 1980 Act, were very much the same as what had occurred previous to that, and that the Secretary of State could refuse registration or deregister a school

if the school was considered objectionable.

Q. Is the reference "objectionable", a reference we find in the Act?

A. Yes.

Q. Is it defined as, for example, issues over welfare, accommodation and so on?

A. Primarily on the quality of teaching, on the buildings, but very little in the 1980 Act on the quality of accommodation, if it was a boarding school.

Q. You indicate, in 1.3.2, that the register, once completed and approved -- and I think it's the register that would be open for public inspection rather than the application?

A. The registrar would consider the application from a school if it was seeking registration. The registrar would also review the registration if a negative report was submitted by HMI inspectors.

Q. But, once registered, was the register open to the public?

A. Yes, the register was open to the public. Yes.

Q. On page 30, I think through to page 32, you provide some information to the background to the Children Scotland Bill that was then in the offing, which became the Children (Scotland) Act, of course. If we turn to 1.3.9, you summarise what the Bill and in effect the

1995 Act envisaged --

A. Yes.

Q. -- in relation to residential schools and inspection. Can you just develop that for me and explain what the final position was?

A. I think the essential elements of it was the requirement for the residential accommodation to be registered with a Local Authority on boarding schools, and that they would -- and the school would be inspected by HM Inspector of Schools on both educational provision and the care and welfare of the pupils, and the issue there was in relation to safeguarding the pupils.

Q. That has broadened the jurisdiction of HMI.

A. It has broaden the nature of the inspection to be similar to what would occur in a residential home.

Q. And I think that was brought about by an amendment to the 1980 Education Act?

A. That's right, a significant amendment to the 1980 Act.

Q. On page 33, at 1.3.11, you have a discussion on the nature and scope, in particular, of the guidelines that were to be promulgated; can you take me through that?

A. There would be general inspection of the schools by HM Inspector of Schools, not just on education, but on welfare. All schools, independent schools and Local Authority boarding schools would be subject to similar

inspections. There would be a rota of inspections, and I think I state there or later that it was agreed that it should be at five-year intervals.

And that there would be an add-on inspection for schools catering for special educational needs, SEN. And that was because of the integrated nature of the provision being provided there, both extensive social work provision along with educational provision.

Q. And you indicate, towards the end of that particular paragraph, that the guidelines indicated that the SWSI inspectors would normally not be a part of the HMI inspection team.

A. That's correct. And I think later on, I think in 1.3.13, 1.3.14, the Minister of State announces -- I think it's the Minister of State -- in Parliament that both the Social Work Service Inspectorate and HM Inspector of Schools work closely. And if there was an issue, the HM Inspector of Schools would ask for advice from the Social Work Services Inspectorate. But that welfare, the welfare function of schools would fall on the HM Inspector of Schools.

Q. Essentially, there are inspections being carried out by the HMI inspector that are looking to both education and welfare?

A. Yes.

Q. And Local Authority inspections as well?
A. The school would be inspected by HM Inspector of Schools for welfare purposes, though I think I state later on that an issue emerged that that would -- that implied that the HM Inspector of Schools would have to go under some sort of training, some form of training, for them to be able to assess the welfare of schoolchildren in residential school.
LADY SMITH: And do I take it that you had the impression that, at least initially, what the SWSI inspectors had to offer was regarded as, if you like, subservient to what the HMIE inspector could offer? And it was dependent on the HMIE inspector saying, "I think they might be able to help", or "Give me guidance, because I want to draw them in"? But the lead always came from the education side; was that it?
A. Outside of SEN schools, that is Special Educational Schools, the issue -- if you like, the wider issue is that a residential school did not necessarily have issues concerning social work amongst its pupils and, therefore, why would you say there should be joint inspections of Social Work Services Inspectorate?
LADY SMITH: The short answer might be that the care and welfare of children is just as important as their education, if not more so. Children who are properly

cared for and their welfare attended to might just learn better.

A. The issue, as presented here, was that the HM Inspector of Schools would undertake training, and I think in the report it does indicate that training was offered and that new staff were brought on board, who had been appropriately trained to conduct that sort of exercise.

MR MACAULAY: Did you find any actual evidence of training?

A. I couldn't locate specific documents, except that the statements -- yes, these inspectors have undertaken special training.

Q. Just to go back to the Local Authorities, the Local Authorities had the duty to carry out inspections of schools registering with the Local Authority?

A. Registering, but not necessarily inspecting.

I think it's quite important to understand that if there's not a social work issue, right, why would you employ professionally trained social workers to conduct an inspection?

Q. Yes.

And on page 35, beginning at 1.3.14, you discuss the format -- that the inspections would take place?

A. Yes.

Q. Can you just develop that for me?

A. The first phase would be conducting an inspection

unannounced, two or three days with a small team of two or three inspectors, gather the information, have discussions, talk to pupils, and also seek out parents to talk to in relation to provision of education and also care and welfare of the pupils at the school.

Q. So quite a broad jurisdiction?

A. It is, yes, and a significant change from the previous period.

Q. Yes. When we looked at the past, what happened: children were not spoken to.

A. Children were not spoken to.

Q. Certainly not parents?

A. Certainly not parents, except in class. From my memory of a school inspector coming in, we were asked questions about the school inspector. That was the only occasion I seem to remember a school inspector engaging with a pupil.

Q. Thereafter there would be a second announced visit?

A. Yes. The second announced visit where any issues had been identified or specific concerns. The Minister would be informed, especially if complaints had been raised. They would look at the issue of pupil attendance, absence or exclusion, and that the Minister, Scottish Office Minister, who held the brief for education, was quite satisfied with that new approach.

Q. If we move on to page 36, at 1.3.17; do you tell us that following upon that second stage, the HM Inspector of Schools were provided with a framework evaluation to complete the report?

A. That's right. That would include looking at preventive arrangements, such as supervision and checks for child protection and safety, emergency arrangements for -- avenues for complaints, knowledge that staff have of pupils, opportunities for pupils to influence the running of the residents' food and diet, and the whole philosophy in practice of nurturing welfare within the school.

Q. If we move on to page 37, at 1.3.21, does the HM Inspector of Schools Report, in April 1999, that the guidelines being followed had stood up well?

A. Yes, they were obviously quite pleased with the way that the pilots had been implemented, and they would now formulate the procedure to be adopted in conducting inspections as a result of the pilot study.

Q. You draw attention here, and I think previously -- although I hadn't picked it up with you -- and that's the role of laymembers, the role they had to play. Can you just tell me about that?

A. Laymembers were appointed to assist the inspection of the residential school. I have to say, it's not very

clear from the evidence that I looked at as to what part they actually played within the actual inspection. This is the reports were retained, or the paper surrounding the reports that were retained, don't say very much about the use of laymembers in conducting an inspection.

Q. You tell us in the footnote, 102, that in 2002 it was reported that there were around 100 laymembers in the inspection team?

A. That's right, yes. That's about as far as I got.

Q. Quite a large number.

A. Quite a large number. But given that they would not be engaged in inspections all the time and inspections were across the whole of Scotland, it's probably not a large number. My understanding was that they might have two or three, at most, laymembers in any one inspection.

LADY SMITH: Can you remind me what the thinking was behind including laymembers?

A. It was partly, I think, to satisfy public opinion that any review of educational provision, including welfare, was being reviewed not just separately within the education sphere, but within the general public interest; that's all.

LADY SMITH: Thank you.

MR MACAULAY: I think you mentioned earlier there was a children's charter that spoke about this.

A. That's right, way back in 1991, 1992, the children's charter, seeking to involve the public and ensuring public support for the conduct of the inspections that were taking place.

Q. On page 38, at 1.3.22, you indicate that a separate set of guidelines for the final inspection of independent boarding schools --

A. Ahead of registration?

Q. Yes.

A. Ahead of registration, yes.

Q. That was published in July 2000.

A. That's right, yes. Clearly, there was a distinction between those schools already registered and new schools who had not been registered, and the process you would follow when you were conducting an inspection and the registrar making a recommendation to Scottish Ministers that the school could be registered. That would include accommodation, staffing resources, the views of Social Services Registering Authority, where in fact pupils had been placed by local social services, provision of support for pupils, pastoral care, personal and social and health development, and the support offered to boarding pupils within the residence.

Q. And a point to -- an important addition that emanates from the Standards in Scotland Schools Act 2000 in

relation to the welfare of children.

A. That's right, yes. That meant that the registrar had to take into account the welfare of the pupils attending the school was adequately safeguarded and promoted. And, therefore, if they weren't, then the -- the school would not be registered, and a school could be deregistered if they were not adequately safeguarding and promoting the welfare of the pupils within the school.

Q. At paragraph 1.3.23, on that page and into the following page; do you pull together what you have been discussing in the previous paragraphs?

A. Clearly, it was more in depth than in the previous period, and that the HM Inspector of Schools was expected to undertake training and child protection.

Certainly, the HMI Inspection Reports I looked at before 1995 would indicate very limited amount of interest in pastoral care and certainly in terms of residential schools, seemed to be concerning the quality of food.

Q. You then have a section, 1.4, headed:

"Secure accommodation."

You set out provisions from the Social Work (Scotland) Act and subsequent related legislation and regulations that set out how a young person could be

placed in secure unit accommodation?

A. That's correct. In 1992, that wasn't any different from the previous period; had a history of absconding; that their physical, mental and moral welfare would be at risk, were likely to injure themselves or other persons, or had been placed by the Court Secretary of State Social Work Department on remand or committed as a result of a grave offence.

Q. You say that in 1986, apart from two schools, the financial responsibility of List D schools was transferred to Local Authorities, which resulted either in their use as part of a portfolio of residential homes or closure.

A. That's correct. I think I've covered that in the second report I did.

Q. Yes. But the two schools where the Secretary of State shared responsibility were Rossie and St Mary's Kenmure?

A. That's correct, yes.

Q. They were two of the larger --

A. Two of the larger that had been retained.

Q. Yes. You may have touched upon this, but the SWSI assumed the responsibility previously exercised by CAS for the inspection of secure accommodation?

A. It was the same officials. If you actually look at the name of the officials before, it's the same inspector.

Q. Just a change in name?
A. Without giving his name; right? It's the same inspector who tours Rossie and St Mary's Kenmure, in 1991 and 1992, and you can see that in the list of duties within the Social Work Service Inspectorate of the period.
Q. Now, if we go on to the following page, you give us some information about the number of beds available in Scotland. At that time -- towards the top of the page -- you say the number was less than 90?
A. That's correct. There was considerable discussion in that period as to the suitability of secure accommodation for children with -- and young people with specific needs, and whether the number in Scotland was far higher than in comparison, in proportionate terms, to that south of the border. And the issue surrounding whether or not the bed accommodation should be increased or not.
Q. I think we see, later, there was an increase?
A. There was certainly a series of incidents which led to the Minister effectively insisting that the accommodation should be increased.
Q. Was that a generally held view or not?
A. I think there was a lot of discussion, and I think there still is a lot of discussion, on the nature of secure accommodation and its appropriateness for young people.

And certainly there was a body of opinion at the time, in 1992/1993, that thought that the number 90 was adequate.

Q. I see here that you indicate that if there was insufficient accommodation in Scotland a child could be committed to a secure unit in England?

A. That's correct, yes.

Q. Now, you go on to tell us about the drafting of secure accommodation regulations, and in particular restating the proposition that secure accommodation had to be approved by the Secretary of State.

A. That's correct, yes. On such terms as he thinks fit, which meant that -- after inspection.

Q. Yes. And the change in principle, I think that you talk about in the bottom end of that paragraph, you say:

"Additionally the Draft Secure Accommodation in 1996 Regulations covering the welfare of children reflected the principle underlying the 1995 Act, that a child's welfare should be safeguarded and promoted. Instead of the principle of Local Authority ensuring the child's care should be conducive to their best interests."

There is a change of emphasis there.

A. There is a change of emphasis and, of course, that correlated with -- if you like, with the nature of inspection of boarding schools generally.

Q. Did that mean then that the inspections after the passing of the regulations were centred on a broader concept?
A. On a broader concept, which included obviously -- I think later on it said about the issue of a care plan and that a secure accommodation unit should have its own development plan, its care plan for the child and young person within the accommodation. And that was different from what had occurred previously, where there wouldn't necessarily be any specific plan for the child or young person in the accommodation.
Q. And would this care plan be, for example, looking ahead to --
A. It would be an assessment of their physical, mental, educational needs. It would obviously have to incorporate the views of the relevant medical, educational and social work authorities as to the best plan for that young person within the accommodation.
Q. So there's this broader concept of care than previously.
I think you say also that an inspection by SWSI could also be in conjunction with the HMI inspector?
A. Correct. That was the position prior to 1995 and prior to 1991.
I think the issues that emerged -- and I think you might want to talk about it later -- is the fact you had

integrated inspections in the way that you didn't necessarily have before 1995; that is the social work service inspector and the HMI inspector would both inspect the premises at the same time and, on occasions, sometimes the medical officer of the Department of Health would conduct an inspection at the same time. So you had an integrated inspection to reflect the fact that you had a care plan.

Q. Yes. At 1.6, then, you are providing us with an overview of what has gone before; can you just summarise that for us?

A. I think --

Q. It's 1.4.6.

A. Sorry, 1.4.6. Sorry, I'm flicking ahead of myself.

Q. It's on page 41.

A. Yes, I know. Yes, yes, yes.

The key element surrounded the issue of being more deliberative, as I say here, about the care plan, that it was especially with a child or young person. That the Social Work Inspectorate, HMI Inspector of Schools, retained their inspection function of secure accommodation, but with a deepened focus. And that, as I said, looking at the integrated nature of the care plan, in terms of both health and educational needs, as well as social needs.

Q. You have a short section, at 1.5, dealing with the provision for local inquiries. This is something that comes out of the 1995 Act; can you just tell us what this involved?

A. Yes. I think the issue that surrounded the 1995 Act was that the then Scottish Office had obviously been obliged to or agreed to conduct public inquiries into both the Orkney and the Fife issues.

These were quite expensive and took some time. The view at the time -- the view within the Act was that Local Authorities should initially conduct an inquiry, which would be a shorter time and so that any lessons that emerged could be learnt very quickly and be implemented within the Local Authority.

Q. At 1.5.3 -- I think you just touched upon this, page 42 -- such an approach, you put in brackets, which in the author's view was to avoid recommending to the Secretary of State a public inquiry was used by SWSI, and so on and so forth.

A. Yes.

Q. And it was a quicker and shorter --

A. A quicker and shorter --

Q. -- a probably less expensive way of --

A. Less expensive. It was -- expenses were met by the Local Authority and not by central government. And in

this case, within I think two years, the situation had been resolved to the satisfaction of the Social Work Inspectorate.

Q. You provide us with examples in that paragraph and in paragraph 1.4 --

A. Yes.

Q. -- and I think in relation to the Marshal Inquiry?

A. Yes.

Q. The Edinburgh Inquiry.

A. Yes.

Q. At 1.1.5, do you draw attention to the fact that implementing the 135 recommendations of the Edinburgh Inquiry was essentially a matter for the City Council?

A. That's correct, yes.

Q. Does one get the impression that the SWSI, for example, did not want to get involved in this process?

A. I think the SWSI understood the implications of the 1995 Act. In the first case, the matter was for Edinburgh City Council to resolve itself. And if there was an issue that emerged, that they were unwilling to do it, then it might be necessary to advise the Scottish Ministers of the need for a public inquiry.

From my reading of the papers, Edinburgh did not necessarily realise that they could hold their own inquiry, until advised by the Social Work Service

Inspectorate that they could and they did.

Q. And it produced 135 recommendations?

A. 135 recommendations for the City Council, yes.

Q. You then have a section headed:

"Central inspection and national standards of care."

Can you just give me an overview as to what you are seeking to cover in this particular section?

A. In this particular section, there was clearly an election manifesto promise by the incoming Government that they would establish national standards of care and that -- and I think initially it was for elderly people and elderly people's homes, but then was broadened to cover children's homes as well and other residential accommodation for children.

And a series of meetings and working groups and working papers produced a number of papers, which set out the national standards of care that would be implemented with the establishment of the Care Commission in 2002.

Q. We are looking now at the lead-up to the establishment --

A. That's right.

Q. -- of the Care Commission under the 2001 Act?

A. That's correct, yes, yes. That's the sort of background to why you actually had national standards of care

coming into force.

Q. In paragraph 1.6.3, you draw attention to a Scottish Office White Paper, aiming for excellence modernising social work services in Scotland. It was this that really prompted the legislation to establish what we call the Care Commission.

A. That's right, yes, yes. It was a parallel, really, to the issue of care for the elderly.

Q. Yes. Then if we go on to page 46, at 1.6.9; do you summarise there the post-2001 Act position in as far as the Care Commission was concerned?

A. Yes, the Care Commission took over the responsibilities of the arm's length inspections of Local Authorities, the inspection of registration of children's homes and in the fostering of looked-after children. It also included the Social Work Service Inspectorate's responsibility for inspection of secure accommodation. Although, of course, the registration of secure accommodation remained with Scottish Ministers, and I think it's quite important to understand the distinction between inspection and registration.

Q. Just so I can fully understand it: if you want to be registered, you have to satisfy the Scottish Ministers that you comply with the relevant standards?

A. The Care Commission would have to inform Scottish

Ministers that they were satisfied that the secure accommodation unit met the relevant national care standards.

Q. Would the Care Commission, in coming to a view, would that be a paper exercise or would they --

A. It would be the result of an actual inspection. Obviously, reviewing the papers that the secure unit had, but also looking very closely at the result of the inspection.

Q. So accommodation would be a relevant factor?

A. Accommodation would be a relevant factor, as well as all -- what I previously said about safeguarding.

Q. You tell us that the SWSI continued to review deaths of looked-after children.

A. Yes, initially -- I should also say the Social Work Services Inspectorate retained inspection of secure accommodation simply because of the necessity to train staff within the new Care Commission to conduct that. But, in addition, of course the Social Work Services Inspectorate retained the brief to review deaths in care and recommend further action by Scottish Ministers or the closure of the case to Scottish Ministers.

Q. And the 2001 Act, the Regulation of Care Scotland Act 2001, did not then impact upon the role being played by the HM Inspectorate of Education?

A. No, it did not, no. They were still responsible for the inspection, including the welfare of boarding schools.
Q. Do I take it from what you have said then that the Local Authority has really fallen out of the picture?
A. Local Authorities are no longer part of the picture of the registration and inspection of residential accommodation.
Q. So then if we move on to page 47, as is, I think, your practice, at paragraph 1.7, you provide an overview of this particular section we've been looking at; are you able very quickly to summarise that for us?
A. The Inspectorate powers remained very much the same in 1992 as it had previously, that the Social Work Inspectorate certainly inspected secure accommodation and reviewed deaths in care, but did not, unless specifically required by the Secretary of State to conduct any further inspection of Local Authority services. That brief remained, if you like, throughout the period.

The significant change really occurred as a result of HM Inspector of Schools being empowered to conduct an inspection of residential schools in terms of the care and welfare of residential pupils.
Q. The one thing you do say is the SWSI was not a large organisation.

A. That's correct, yes.
Q. And I think you did mention they essentially inherited the personnel from CAS?
A. From what I can see, it was the same personnel from CAS, and the number of inspectors who, if you like, reviewed and oversaw childcare and looked-after children remained the same. I think one assistant chief social work inspector, plus three or four other inspectors, one of whom conducted the reviews of deaths in care and also seemed primarily responsible for inspecting secure accommodation in this period.
Q. Section 2 of the report, Professor, looks at deaths in care over this period, 1992 to 2005 and you begin that exercise on page 50 of the report.

You begin, at 2.1, by looking at the administrative procedures after deaths of looked-after children in care; can you perhaps summarise how that operated in practice?
A. In practice -- and this dated from 1962 -- the Local Authority, as I think I said previously, should telephone Social Work Services Group within one working day, with the details of the child, the legal circumstances of their being looked after, and the brief details of the cause and circumstances of their death, if known. Then that should be confirmed in writing,

with the death certificate as soon as available and, within a month, the Social Work Services Group will be sent a detailed report of supporting information of the relevant documentation.

Q. Quite strict time limits?

A. Quite strict time limits to get the information in, yes, yes.

Q. Would the subsequent report also make clear if material about the parents or anyone of parental responsibility had been informed of the death and what support may have been given to family?

A. Any parent of the child would be given support in terms of the death of the child, if they were fostered or in a residential home.

Q. You go on to tell us what the procedures would involve once the report had been made and reviewed, and you deal with that at page 2.1.3.

Can you just tell us about what points would be relevant here?

A. I can't be absolutely certain of the position before the 1995 Act. But, certainly in 2002, the information that would be supplied or expected to be supplied by the Local Authority would concern the arrangements for the child's welfare, assessment of whether action had been taken or not by the Local Authority in contributing to

the child's death, identifying any lessons which need to be drawn to the attention of the responsible authority, or other authority or agencies, and if necessary as a result of that case, review the legislation, policy, guidelines or practice implications of the case or emerging trends, which might result in the regulations concerning looked-after children being altered.

Q. There is also some medical input from the Health Department's Medical Centre?

A. Yes. As really dating from 1962, the papers would be sent to the Department of Health Medical Officer, who would review the papers and come to a judgment on whether or not any further information would be required.

Q. You provide us, on page 52, at 2.1.5, the statistics, I think for the period 1989 to 1998, a 10-year time period.

A. Yes, yes. As you can see, approximately half the deaths were attributed to natural causes; nearly a quarter of the cases, substance misuse; road traffic accidents. Then a list of others, such as fall from building, drowning, hanging, accidental, hanging suicide, house fire, murder and accident.

Q. Are you able to say now how that number compares to previous 10 years, for example?

A. It's not absolutely clear. I'm fairly confident that was broadly the number of the previous decade and subsequent decade, from published sources. But that's not necessarily the actual distribution in terms of cause of death.

Q. The next section then you begin to look at deaths. At 2.2, you have a number of case examples where we have deaths from natural causes, and you provide these examples.

Can you see the first three examples, for example 2.2, 2.3 and 2.5, that you are looking at the deaths of children who were severely or profoundly disabled?

A. That's correct, yes. I wanted to ensure the Inquiry understood some of the circumstances of the deaths of children from natural causes and that one would not simply concentrate on this report on deaths from other causes. So you could see that it was clearly stated as the result of the review by Social Work and Service Inspectorate, Department of Health's Medical Officer, that everything possible had been done for the welfare of the child pre their death.

Q. In these cases.

A. Yes.

Q. We are looking at children, the first one is by age 14. We then have an eight-year-old profoundly disabled

child, at 2.2, and then there is an 11-year-old girl, who, again, who had cerebral palsy.

A. Yes.

Q. So disabled children who probably did not have a significant lifespan in any event.

A. Their life expectancy was not very long.

Q. Then, at 2.6, you give examples, under example 4, of a number of infants who died, again, as a result of natural causes, but whose mothers were substance misusers.

A. That's right, yes. I wanted to bring out certainly one case at least, where there were concerns surrounding the support given to the child in the circumstances of the mother's substance misuse.

LADY SMITH: That was the case where there was a home delivery, and when the child died at a matter of months old, criticism of the agreement to do a home delivery in the first place, where the sort of support the child would have had in the maternity unit wouldn't have been available.

A. We need to bring out the depth of the review that was taking place with the Social Work Inspectorate and the Medical Officer.

Q. Clearly, the children that you are looking at there are vulnerable children.

A. Yes.
Q. You have a section dealing with deaths from road traffic accidents. I think you provide just one example of that, and this is in connection with a 15-year-old boy, who had been known to the social work department for a number of years.
A. Yes, that's correct. I'm sorry, I couldn't get any more in, but it depended on extent of the papers that were surviving.
Q. Yes.
A. And this certainly came across as indicating, again, the extent of review undertaken by Social Work Services Inspectorate and the Department of Health's Medical Officer. And in this particular case, the issue surrounded the involvement, sustained involvement of psychological services to support the boy, and the criticism that perhaps more should have been done.
Q. This was a boy who had had a number of different placements, I think?
A. Yes. Had a history of absconding from the placements, often involved breaking into and out, driving cars, et cetera.
Q. He had an attraction, I think, to stealing cars?
A. Yes.
Q. That's what sadly killed him, in that he was in a stolen

car with three others from Kibble(?), I think, and was critically injured?

A. That's correct, yes.

Q. Your conclusion in relation to these cases that you've been looking at, at 2.3.3, on page 56; what's your view?

A. The evidence suggests that from the review of the deaths in care that the Social Work Services Inspectorate and the Department of Health's Medical Officer was reasonably satisfied with the services that had been offered to the particular children involved, and that they could advise Scottish Ministers that the cases could be closed. And a formal letter would be issued.

Q. That was the procedure?

A. That was the procedure, yes. And I think I want to bring out very clearly that there was a formal procedure of reviewing and then closing the case.

Q. That's quite important, because I think we see later on that may not quite have been followed?

A. Precisely, yes, yes.

Q. We then have a section, Professor, dealing with deaths caused by an accident. This is at 2.4. I think you give one example and in this case, in 2001, you tell us that an 18-month-old boy, who was being looked after by an elderly carer, strayed unnoticed out of the garden and his body was found in a nearby stream, evidently

drowned.

What transpired in this particular instance?

A. What transpired, and it's quite a substantial file on this one --

Q. Can I just say this was very much to your credit, some of these files are hundreds of pages long.

A. Yes, I know.

Q. They're not -- but this shows you, I suppose, the amount of work that goes --

A. That's what I was trying to bring out, that the extent of review was substantial. And in this particular case, the officials concerned, the Inspectorate and officials concerned looked in detail at what occurred and the lessons that this particular Local Authority should learn in terms of the appropriateness or not of the foster carers.

Q. And there was a failure here --

A. There was a failure of procedures within the Local Authority.

LADY SMITH: You describe the carer as elderly, without giving us an indication of what age that was; did you have an indication?

A. I think retired.

LADY SMITH: Retired.

MR MACAULAY: But I think the message that comes out of the

material, and I think possibly your own analysis, is that the carer was not able to keep up with a child that was beginning to move.

A. With a toddler, not -- moving around quite speedily, and the elderly carer could not keep up with the pace and lost sight of the child.

Q. Was the essential point here that the placement was designed to be a short placement?

A. It was designed to be a short placement, which might have been acceptable. But turned out to be a long placement, which clearly is unacceptable, and breached the Local Authority's guidelines.

Q. During the extended period, the child became more active, and that's what led to the child's death?

A. Yes.

Q. At 2.4, you indicate this particular case brought out two issues in the Scottish Executive's approach to the review of deaths; can you tell us what these were?

A. I think the Inspectorate and the Young Person and Looked After Children's Division -- sorry, long name -- they saw it as their principal function, to assist Local Authorities to develop best practice.

They were not necessarily discharging any statutory duty in undertaking a review, but it highlighted the importance of these reviews in ensuring that best

practice was kept up-to-date within Local Authorities. And the information would obviously be supplied, not necessarily the details of the case, but, if you like, the broad nature of the death and the breach of the regulations within this particular council to other Local Authorities.

Q. Your next section is:

"Deaths connected to substance misuse and alcohol."

We're still on page 57. And the first example, at 2.5.2, is one of a boy, 14-year-old boy, in 2001, who died from:

"The aspiration of gastric contents following the consumption of alcohol."

Can you just describe what happened here?

A. Well, the parents of the boy had purchased alcohol for themselves and the boy and his brother. They obviously -- the boy obviously drank too much, became unwell during the night, but was, after an ambulance was called, pronounced dead on admission to hospital.

The child was being looked after under terms of a home supervision for a substantial period of time, had been placed on the Child Protection Register in consequence of the conviction of the father for indecent assault. So this was a case where the family were certainly known to the Local Authority for some time.

Q. Looking to what the SWSI Inspector recommended, at 2.5.3; did he recommend that the Local Health Board Trust should look at the effectiveness of local arrangements for providing young people and their parents with alcohol counselling?

A. That's right, yes. Clearly, there ought to have been a better risk assessment and advice given in such cases. I don't think they necessarily said that the boy should have been placed with the parents. But, nevertheless, there was certainly criticism of the support given.

Q. Did it also transpire that this boy suffered from epilepsy, at 2.5.5?

A. That's correct.

Q. And for the year preceding his death, he had not received his epilepsy medication?

A. Yes. I thought this was an important case to bring to the Inquiry's intention because you can see the depth of the Medical Officer's -- Department of Health's Medical Officer's review of the case and his concern in terms of the support given, given that the child -- the boy suffered from epilepsy.

Q. Was there a recommendation made that if children have ongoing medical problems -- during a home supervision requirement -- with a chronic disorder, there should be discussions between health and education services?

A. Yes. I think this brings out the fact that what you've got is a particular local issue, resulting in guidance being given both locally and nationally, in terms of alcohol and drug abuse.

MR MACAULAY: My Lady, that is coming up to a quarter to.

LADY SMITH: We'll take the morning break just now, Professor Levitt, and sit again around midday. Thank you.

(11.44 am)

(A short break)

(12.00 pm)

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

A. Yes, thank you.

LADY SMITH: Thank you. Mr MacAulay.

MR MACAULAY: My Lady.

Now, if we turn to page 59 and look at the next example that you give under this head, at 2.5.6, this is another case in the same year, which is 2001. A teenage girl, who was subject to a supervision requirement with a condition to reside at a young people's centre, but was on home leave when her mother died after a fall from a boyfriend's flat.

Can you just highlight what the problems were here?

A. Yes, again, I wanted to bring out the depth of the

inspectorial review of the case papers, which is interesting in itself, that they certainly spent a lot of time on this particular case.

Although the Local Authority had provided a full case history and accounts leading to the events, it appeared to the Inspectorate that there were deficiencies in the care being provided; that there had been lack of long-term care planning and case management, and there was an issue surrounding the suitability of the placement resources.

And in addition, it was known to the Local Authority that there was a risk of the young girl residing with her mother and also her boyfriend, given their particular drink and drug history.

LADY SMITH: This was another case in 2001, I think, wasn't it? The same year as the previous one.

A. That's right, yes. And although the Medical Officer noted that medical help had been given for the girl's drug and alcohol misuse, that helped had been refused. It would appear that she did eventually agree to see a counsellor on the issue.

There was certainly a lot of correspondence with the City Council, which was not necessarily to the satisfaction of the Inspectorate in terms of the process and procedures that the Local Authority had used to

support the girl.

Q. I think in the file -- although you don't flesh that out here -- there is a suggestion she may have jumped, in fact?

A. Yes.

Q. After a row with her boyfriend.

A. Yes, that's right, but it's not clear whether that was the result of drug misuse or alcohol, or both.

Q. Can I just draw attention to one point, halfway down page 60? Because what you narrate there, Professor, is in one year alone, 1999/2000, there had been eight changes in placement, which pointed to a lack of suitable placement resources.

I think we have seen this quite regularly, that placements change and change.

A. Placements change and change, but the issue in this particular case, it would appear that the most appropriate placements were not being provided, which would have supported the girl in her misuse of alcohol and drugs.

Q. You then, at 2.6, have a section where you look at deaths of those who had been in residential homes.

A. Yes.

Q. You begin by telling us that the statistical breakdown of deaths in care, the 1988 to 1989 period, did not

indicate the number who died while being accommodated in residential care?

A. Yes, correct.

Q. So there are no statistics for that?

A. No, but I hoped you might be interested in that.

Q. That's well within our terms of reference.

A. But, unfortunately, I couldn't provide you with details.

Q. But the next case, 2.6, a boy who had drowned. I think he was -- yes, 2.6. Can you tell us about what happened here?

A. Yes. This was a young boy who was in the care of a Local Authority. He drowned whilst swimming fully clothed during an organised outing, and the issues surrounded whether or not there should have been additional support for the outing, to ensure that there were sufficient life guards to support that particular outing.

Q. This is a case in which there was an FAI; is that right?

A. That's right, yes.

Q. Before Sheriff Nigel Thomson. It was he, I think, who recommended, if you turn to page 62, that a panel of life saving social workers should be established. But I think the response to that was that would be difficult to ensure.

A. It would be difficult to ensure, but they could give

a recommendation that clearly such outings would incur a risk if there weren't sufficient life guards in attendance.

Q. I was intrigued by the fact the suggestion is that this boy had drowned whilst swimming fully clothed. But, when you look at the file, what he was actually doing was swinging on a rope from the bank?

A. Yes.

Q. With the intention of getting back to the bank, but in fact he fell into the water.

A. Right. I think the issue there was that he perhaps was not an accomplished swimmer, or perhaps couldn't swim at all. This is another issue that was brought out.

Q. The next example, this is a 15-year-old boy, who had been in a Strathclyde Regional Council home and was found hanged in a public lavatory in a nearby town. I think the home he had been in, according to the file, was Bells Hills children's home in Wishaw; can you tell me what happened here?

A. The Sheriff in the determination found there was no reason why the boy would take his own life, but it would be difficult for the Local Authority to assess what risk he might pose if he left an establishment that he was placed in.

There was clearly a background to his parents, the

objection of his mother, the attitude of his father, and that clearly the boy's state of mind wasn't particularly good during the period in which he was in care. And that there was clearly evidence of depressive illness in the boy.

The issue, I think in terms of inspection, was, again, the detail -- the review Medical Officer undertook, and the fact he contacted the Royal College of Psychiatrists and that they would meet with the directors of social work to discuss the issues of appropriate care for children with depressive illness as a result of their parents.

Q. At the end, you tell us at the same time the Chief Inspector of Social Work accepted that guidance should be provided on psychiatric services for all children in care or under supervision, and that it should also be available to the education service to residential and boarding schools?

A. That's right. Again, this case brings out the ramifications of this case in terms of taking guidelines and advice further.

Q. Your next example, on page 64, 2.6.5, again, this is a boy, 16-year-old boy, who was found hanged in 1998, and he appears to have been in a bed and breakfast placement.

A. That's right.
Q. What happened in this case?
A. The death was attributed to suicide. There was no Fatal Accident Inquiry. There were clearly behavioural issues at home, which included alcohol and cannabis. Perhaps the use of heroin, although this is not sustained. A record of school truancy, and that the boy had been placed under Local Authority supervision.

The boy was educationally unsettled and moved between schools. And although the Medical Officer felt that the medical care was appropriate in this particular case, the Social Work Inspectorate had doubts as to the support given by Local Authorities and Social Services in terms of supporting him in education and also ensuring he was -- if you like, his care plan included both personal support as well as educational support.

There was also criticism of being placed in a B&B, rather than a residential home or with foster carers.
Q. At 2.6.7, as we have seen before, that for the three years preceding his death the boy had resided in seven settings and attended education in four settings.
A. That's correct, yes. Again, I thought you might be interested in this case because of the depth of review that the Social Work Services Inspectorate had and his assistance in obtaining more papers concerning the Local

Authority's support for education and in Personal Social Services.

Q. And the places that he was being placed into, the placements seemed to break down. But if we look at page 63, it's the quote from the report. Halfway down the quote, do we learn that two days before his death his social worker told him that he must move again, but could not tell him where he might go, other than to another hostel?

A. Yes. That again indicates the concern that the inspector had as to the -- not necessarily the relevance, but the significance, really, of the lack of support being given, being completely unclear as to where that young person would reside and the impact it would have on their mental well-being.

LADY SMITH: That's the quotation in 2.6.8, on page 65, not 63, I think; is that right?

MR MACAULAY: Yes.

We see, at 2.6.9, the Inspector's concerns, and we see, at 2.6.10, that the HM Inspector of Schools agreed that the case made very sad reading and recommended that additional reports should be obtained, and he sets out what these would include.

Does it appear that after -- what you tell us at 2.6.11 -- the case was not followed up?

A. That's correct, yes. Again, this case, I think, brings out to the Inquiry the significance of the use of the HM Inspector of Schools reviewing the case. It wasn't just simply a question of the Social Work Service Inspector and the Medical Officer, it was also the Education Inspector looking at the appropriateness of the schooling. Yes, the papers were lost, simple as that.

Q. They were eventually located a year later, and I think there was an agreement that no further information would be sought?

A. That's right, yes. The papers were lost and, by that time, clearly it was felt that there was no point in pursuing the case with the Local Authority.

Q. Do we see in some of these cases that they take considerable time to come to an end with the closure of the case, particularly if there's an FAI?

A. I think in many of these cases, particularly where -- which concerned substance misuse or residential care, the depth of the review was such that the Social Work Services Inspectorate would have to consult with -- in this particular case with the Medical Officer and HMI, who would then have to get reports from the relevant schools, education authorities, local Social Work Services and also the NHS, the local health departments, and that could take time. And I think, yes, it's

something that I think I wanted to bring out, the actual length of time it would take to review quite problematic and quite difficult cases.

Q. The next example that you provide us with, Professor, on page 66 -- it is 2.6.12 -- and this is quite an important case, this one.

A. Yes.

Q. It focuses on the lack of availability of secure care; is that correct?

A. That's correct. This is quite important in terms of the impact it had on policy and provision in subsequent years.

Q. So far as the facts are concerned, do we learn that in 1996 a 15-year-old Dundee boy was murdered in a stabbing accident?

A. That's correct, yes.

Q. He was subject to a residential supervision requirement by Tayside Regional Council, with a condition authorising secure care. But the Minister was informed that at the time no secure accommodation was available to the Local Authority and he was residing in "his own squat"?

A. That's correct, yes.

Q. Can you just develop for us what happened here?

A. There were clearly some issues concerning Tayside

Regional Council and the availability to secure suitable alternative accommodation in the absence of them being unable to place the boy in secure accommodation as Rossie, St Mary's Kenmure and the other small secure units were full at the time.

The boy had obviously been murdered, and four boys had been charged with that.

The Medical Officer, given a review of the case, found it was quite incredible that there was no secure accommodation available.

Clearly, the case and the depth of the review of the case indicated that -- by medical officers -- the child had not undergone any review by a psychiatrist or clinical psychologist, and very limited information as to the involvement of the Health Services throughout his career in care.

Q. You provide us -- I'll look at them in a moment -- with some quotations, I think from ministers. But if we look at 2.6.14, we talk about -- it says that according to the file a 17-year-old was convicted of the murder.

A. Yes.

Q. And two others, a culpable homicide and another of assault, but that's just by way of background.

But we see there that in response the Health Department's Senior Medical Officer reported that they

found it "quite incredible" that secure accommodation was not available when required, so that was the response to the proposition --

A. Yes.

Q. -- that he was, as it were, in his own squat because a place could not be found.

A. A place could not be found suitable for his care needs.

Q. Was it accepted that had a place been found, then he probably would not have suffered the fate he did?

A. That was the view of the Social Work Services Inspector, that the death might have been prevented. Clearly, this boy had a history of absconding and committing various offences, clearly the children's panels who authorised placement in a secure accommodation accepted that was an appropriate place where he should be.

Q. We were told, at 2.6.15, that the children's panel were advised that the Local Authority could obtain a secure place in England?

A. Yes.

Q. But I don't think the children's panel found that particularly attractive?

A. It wasn't particularly attractive. But I think the Inquiry needs to remember that ultimately the placement would depend on the Chief Social Work Officer of the Local Authority, and if they wished to secure a place in

England, I think the legislation allowed them to do so.

Q. Now --

LADY SMITH: No doubt there would be cost implications?

A. I'm not sure there would be an awful lot of difference in costs between being placed in Rossie, up the road from Dundee, than south of the border.

LADY SMITH: We have come to 1996 here; can you remind me whether by this time children from England were also being placed in secure accommodation in Scotland? Because I know that started to happen at some point and I just can't off the top of my head remember.

A. I haven't seen any figures suggesting that. There are odd references to English children being placed in Scotland. But, in terms of this particular case, I've no evidence that the secure accommodation was full because of placements from south of the border.

Q. Thank you.

At this particular time -- and this develops later, and this is the quote on 2.6.15, on page 67 -- are we told there was a review of secure care that was ongoing?

A. Yes.

Q. And in due course that reported then?

A. There was an ongoing discussion within the Scottish Office and within the Social Work Services Group involving outside consultants that believed at the time

that 90 places were all that were required, and that's the context in which this quote is placed.

Q. If you look at 2.6.16, the Inspector has, halfway down that paragraph, noted two issues of concern.

First, it appeared that during the previous year the boy experienced a change in his social worker, and it was not fully evident who was consulted within the social work department in bringing the case to the children's panel.

Second, it was the usual practice within secure units that a child psychiatrist or clinical psychologist would be consulted.

So had he been put into a secure unit, then he it would have to him that sort of medical input?

A. That is correct, yes. I think what's important with this case is that there was clearly an issue surrounding the procedures within local Social Services, that the boy's social worker seemed to change quite frequently, and that it was not fully evident who actually brought the case in the children's panel, from the papers that they received.

In addition, that some time prior to admission to the secure unit, a child psychiatrist or clinical psychologist would have been consulted and would therefore have been able to advise the appropriateness

of secure accommodation.

Q. At 2.6.17, have you set out in quotes the response of the Minister's Private Secretary?

A. Yes.

Q. Can you just tell us what -- I think there he's essentially narrating what the Minister's response was.

A. That he had been assured there was sufficient secure accommodation in Scotland. Again, that reflected ongoing discussion within the Social Work Services Group with their consultants, that 90 places was adequate.

Q. The quote ends:

"He [the Minister] feels that this verges on the absurd."

A. On the absurd. That a placement was required and one could not be found, given the length of time that they were waiting for a secure placement. And that they were left in the flat on their own.

Q. Was there also a suggestion here that other children's homes in Scotland had refused to accept this boy?

A. The boy had a record within a number of children's homes in terms of his behaviour, and I assume it simply got round the children's homes not to accept this boy. Hence probably why secure accommodation was thought appropriate.

Q. If we look at 2.6.22, on page 69, this is the Minister

himself agreeing with the recommendations and his Private Secretary minuting that. He's very concerned to learn that this episode arose because there was no secure accommodation available:

"He believes that should never be allowed to happen and that sufficient accommodation which is secure must be made available throughout Scotland."

So this provides ammunition at least for those who are trying to broaden the secure estate.

A. Yes. I think that it's quite important to understand that this is a ministerial direction being given to increase the secure accommodation estate in Scotland, and that the Minister was rejecting, if you like, professional advice coming in that 90 was an adequate number, given the needs of Scotland.

Q. It's clear the Minister is taking a pretty strong line here.

A. Extremely strong line, in terms of when ministers do or do not get involved in particular cases. But this shows that a death in care did result in ministerial intervention and ministerial direction as to future policy.

Q. Would this direction feed in then to the decision that was ultimately made to extend the secure --

A. Yes, I think I've got that in the following section.

Q. Yes.

The next example you give, on page 70, at 2.6.23, also raises the problem about the secure estate. But this is an example when, in 1999, the young person -- that Looked-After Children's division, were informed of a 16-year-old girl in Glasgow from heroin toxicity at a private house. And she had been living in Local Authority supported accommodation and was very troubled, involved in drugs and prostitution; that's the background.

A. That's the background to this case, which again resulted in ministerial intervention and direction, and this was at a time when in fact the subsequent -- subsequent to the previous death, the secure estate had been increased and this was, therefore, an issue surrounding whether or not the secure estate was sufficiently developed to cater for such children who suffered from substance misuse, particularly girls.

Q. It appears from what you tell us in that paragraph that in this case the children's hearing decided she should be placed in secure accommodation, but the Glasgow Secure Screening Group decided not to recommend implementation of that order; what do you make of that?

A. This is the internal process of when a children's hearing makes a decision in terms of recommendation, the

local Social Services Review Group, decided after reviewing the papers that they would not actually implement the decision. This was not the view taken by Glasgow's Chief Social Worker, as to the decision within the Local Authority social work department for that decision to be reconsidered. In the meantime, the girl remained in supported accommodation, before her death.

LADY SMITH: Professor Levitt, in the third-last line in that paragraph, you quote that the girl was "presenting to herself", I'm not sure I follow that. Is that presenting as a risk to herself?

A. Presenting a risk to herself in terms of her substance misuse.

LADY SMITH: Right. So it's not just "presenting to herself", because that doesn't tell me very much.

A. No, no, what that means in professional language is she presents a risk to herself in consuming heroin.

LADY SMITH: Thank you.

MR MACAULAY: We see, at 2.6.24, the -- and I think this is when the Glasgow took the line it did in relation to secure care, because the Assistant Chief Social Worker Inspectorate minuted this:

> "As I observed before, no reasons were given on the screening form for the decision not to implement the secure accommodation authorisation, despite the views of

the children's hearing, the social worker, the safeguarder, the psychologist (who had known xxxx for some years) and the residential key worker that should xxx continue along her present path, she will end up dead."

A. This is an example where, if you like, the main social work Inspector, who was reviewing the papers, sent the papers, if you like, upstairs to their Assistant Chief. The Assistant Chief who oversaw the children's and young person's brief within the Social Work Inspectorate. And I think it's significant that the papers, if you like, went upstairs, and you had an Assistant Chief Social Work Inspector effectively confirming the view that the child, young girl, should have been placed in secure accommodation.

So it's the procedural element also attached to it, that the papers were being reviewed further up the line and a decision being taken that this young girl should have been placed.

LADY SMITH: And, importantly, the procedural element involved in not recording reasons for failing to follow what had been recommended.

A. Yes. And I think the criticism, therefore, is quite important if it's coming from an Assistant Chief Social Work Inspector, if you like, number two in the Social

Work Services Inspectorate hierarchy.

MR MACAULAY: If you look at 2.6.28, on page 72; was this a case where a Fatal Accident Inquiry was announced in June 2000?

A. Yes, it was clearly the case that the Shadow Minister, who was also a local MP, contacted the Scottish Executive Minister for Education and Children, that they were concerned and wished a Fatal Accident Inquiry. And then there were subsequent papers, dealing with the issue of how to respond to the letter from the Shadow Minister.

Q. Can we see the Sheriff, Sheriff Agnes Duncan, I think, though not convinced that secure accommodation would have helped the girl in the long return, confirmed the concern on the availability of secure accommodation, and in her determination stated:

"No doubt secure accommodation is not the answer in the long term for such young persons, but there should be some secure accommodation, even as an interim measure, available for those young persons who, quite literally, have gone out of control, by way of drugs, and associated problems."

A. That's correct. So the Fatal Accident Inquiry Sheriff is basically confirming the view of the Social Work Services Inspectorate.

Q. She goes on to say on the following page, at the top:

"It was depressing to hear that the root of the problem, as usual, can be traced back to resources, facilities and funding."

A. That's right, yes, yes. And I think the next section then goes on to discuss the further extension, expansion of the secure estate, particularly for young girls.

LADY SMITH: Now, that was a statement made by the Sheriff in 1999; is that right? Sheriff Duncan?

MR MACAULAY: December --

LADY SMITH: Sorry, yes, the FAI was issued then, and the death was in 1999.

That's a statement from a Sheriff who by then was very experienced. She had been a Sheriff for many years and was in as good a position, if not better than anybody, to make an observation like that.

MR MACAULAY: What happened then following upon the Sheriff's determination?

I think you said there was an increase in the number of places.

A. There was an internal review, and I think the next section of the report --

Q. Deals with that.

A. Or -- there was that. Or there was an internal review which indicated that the secure estate should be

increased and particularly for young girls, whose numbers were requiring some form of secure care, at least from the children's hearing, was increasing.

Q. Then moving on to the next example, example 6, at 2.6.31, page 73, and this is in January 2001 the death of a 14-year-old boy at Kerelaw and this is in the open unit and the cause of death was thought to be drugs related. Can you give us a description as to what happened in this case, Professor?

A. In this particular case, the boy had, I understand, been in and out of residential care for some time and had been placed at Kerelaw's open unit for their own safety.

The boy in this case had, in 2.6.32, on page 74, substantial substance misuse in his career, aggressive violent offending behaviour, reluctance to engage with any healthcare services, chaotic lifestyle and there were some issues surrounding the involvement of the relevant Social Services within the care plan, if you like, following the 1995 Act.

There was no indication on the record he'd been medically examined. There is no case that he had been referred to a drug addiction counsellor and it wasn't very clear what sort of referral pattern in this case had actually occurred. In effect, I think there was criticism that the boy had just been sent to Kerelaw and

Kerelaw was meant to sort him out.

Q. And if I can pick up the point at the top of page 74, and this is an indication of ministerial involvement, the second line:

"The Minister had also raised then ongoing concern on the education provided at the school and was informed that whilst the HM Inspector of Schools had reported on secure unit, it had not conducted an inspection in the open unit, principally as a result of staff resources."

And it appears the Minister wasn't very happy with that response?

A. No. I think this case is yet another indication of when the papers end up in the Minister's office and in fact if you like, the directions that this case should be thoroughly reviewed occurred.

It was obvious that there was an issue surrounding the inspection of the schools. The secure unit may have been reviewed, but not the open unit. And the Minister was clearly unhappy that one part of Kerelaw should be inspected but not at the same time as the open unit.

The reason for that is simply because secure accommodation was being reviewed more frequently than an ordinary school, and the open unit was considered an ordinary school and therefore was not subject to the review that would occur in terms of secure

accommodation, even although the Inspectorate are on the same side, if that makes sense.

Q. The Minister clearly had assumed that if you're doing an inspection you do them both at the same time?

A. That's right. But there was a different sort of pro forma protocol for dealing with secure accommodation inspections which were more frequent than ordinary open residential schools, which, I think, I said earlier should occur every five years.

Q. 2.6.34, I think the SWSI Inspector noted a number of weaknesses in the arrangements for the boy's safety and welfare of the school?

A. There was no assessment of risk management that the boy might require in terms of his substance misuse and his behaviour. There is no record of any advice given by the staff of the open unit in terms of his substance misuse and there was clearly an issue of the handover between the day and night staff to check the boy situation frequently and there was finally no designated first aider on duty when the boy was actually discovered.

Q. Can we turn to page 76, 2.6.35, because we are told that two years elapse and Health Department's Medical Officer notices that he had not received information that he had requested, but he also noted there had been an FAI,

which had concluded in January 2002?

A. Yes.

Q. So there seems to be a gap in time.

A. It's not clear why that gap occurred. It may well be because an FAI had been called, that those papers were not being sent to the Medical Officer, but the Medical Officer basically agreed with the Social Work Inspectorate that the boy's psychological and addiction elements had not been comprehensively assessed at Kerelaw and there was no management plan in relation to his care plan for this particular boy.

Q. If we look at 2.6.36, page 76, I think we are given some information about what the Sheriff concluded and in particular there were no defects in the Local Authority's system of working which contributed to the boy's death, nor in the actions taken by the Local Authority to improve its residential care services. So that's one of the findings made by the Sheriff?

A. That's one of the findings made by the Sheriff, but further down in that paragraph, the Local Authority should review the operation management of its alcohol and drug counselling services, particularly when young people were reluctant to engage and where there is liaison between community and residential-based services and there should be appropriate arrangements in place to

protect children and young people in the event of coming into contact with a retired minister, which the boy had befriended.

Q. If we look at the last section of this particular section, page 77, 2.7, you give us an overview of what you have been discussing over the last little while. Can you just perhaps summarise that for us?

A. Yes. The procedures basically followed that which had evolved since 1962 and reinforced by the 1995 Act, that there could be three outcomes to the review of each death.

The first would indicate that the inspectors and Health Department's Medical Officers concluded that the provision of care had been at a high standard and no lessons were required for practice or implications for wider policy.

Second, it would indicate that there were certain issues within the care provided and that the local agencies should review their practises or organisations with the aim of securing improvement, that is that the issues concerned the Local Authority.

The third was that the issues of wider national concern, which if not requiring ministerial action, then further consideration at official level before recommending a future practice or development of service

organisation.

I have given some examples of the way that ministers got involved and effectively issued directions.

Q. Would Ministers be interested in those cases that might get some press publicity?

A. I think that's probably the case or where a fellow MP or MSP brought it to their attention and they felt they are required to be briefed as to the circumstances surrounding the death. They may not. It's not clear from the papers exactly how many went to the relevant minister, except in the cases, which I've mentioned, which resulted in ministerial directions.

Q. You tell us that the cases indicate how the procedures operated. I think we have seen that?

A. Yes, yes, yes.

Q. And the final comment on 2.7.3, page 78, although the NHS services were commended for the actions that they had taken to provide a high standard of case, it can be seen that on occasion concerns did emerge?

A. There were concerns in the case of staff qualified in life saving for outdoor activities or greater healthcare in counselling support for children who were substance misusers or in the support of local service organisations and professional advice from the Social Work Services Group, Young Persons and Looked-after

Children Division, and so I think what I wanted to bring out here was that these cases are significant in terms of its impact on not just local policy or local practice, but of wider national practises, concerning the Health Services, the Education Services, and Social Work Services at a local level.

Q. Can we move on to section 3 of the report, where you deal with secure accommodation units, 1992 to 2005. You provide a short introduction, setting out what you're going to cover.

If I go to 3.1, the introduction, you remind us what is meant by "secure accommodation" and as we know it's there to restrict the liberty of young people?

A. Who have complex needs for a variety of reasons and who might be placed there by a children's hearing or by the Secretary of State or Scottish Ministers.

Q. And you give us some insight into the frequency of inspection of the issue and what do you tell us, at this time?

A. At this time, in 1992, they were on a rolling three-year cycle of Social Work Inspectorate, HM Inspector of Schools and it's important when we relate to the Kerelaw incident that you have a three-year being standard whereas with an ordinary residential school it was five years. So I'm bringing that point out again.

You can see here that there was fairly intense review in the beginning of this period of secure accommodation to ensure that the requisite standards had been met and the Secretary of State could continue to approve the unit for a certain period of time.

Q. That's important, isn't it, from the perspective of the unit, that the inspection is sufficiently positive, that the unit can be approved to continue forth for three years?

A. That's precisely the point. Now, I think if you're looking at it historically, then this is certainly a change in policy, that you've got a much closer examination at frequent intervals of the appropriateness of secure accommodation.

Q. At 3.2.1, just going back a bit, I think in the first paragraph you make reference to the secure accommodation Scotland regulations but over the period we are looking at these were updated?

A. These were updated after 1995.

Q. But at 3.2.1, the beginning of 1993 the sanctioned accommodation in Scottish secure units totalled 84 places?

A. That's correct, yes.

Q. And you describe the nature of the units that there were two or three I think larger units, there is St Mary's

Kenmure, Rossie and Kerelaw?

A. Yes.

Q. But there were also other units that accommodated a small number of children?

A. That's right, yes, for local needs, Howdenhall, by Lothian Regional Council had five places, High Trees, managed by Dumfries and Galloway Regional Council, held two, Rimbleton House, Fife Regional Council, held two, and Polmont Youth Care Centre, managed by Central Regional Council, also two. My assumption is that if they needed immediate placement they could find one.

Q. I take it these would be very much temporary placements, because there wouldn't be any scope for education?

A. No, no, a temporary placement to await one of the other units having a bed available at Rossie, Kenmure or Kerelaw.

Q. As we read on from the point made by the SWSG that's in quote, that Rossie and Kenmure are both large, secure schools, not merely units, designed to provide long-term care, so that's where the children are kept, but also educated there?

A. That's right, yes. That's why you have the education Inspectorate turning up on a three-year cycle with an integrated inspection with the Social Work Services Inspectorate.

Q. Now, at 3.2.4, on page 81, there is some involvement here between the Chief Social Work Inspector and the Chairman of the Board of Governors of Rossie. Perhaps just on that point, in relation to an establishment like Rossie, these establishments, the bigger, is larger units, they would be governed by a Board of Governors?

A. They were voluntary organisations, with a separate Board of Governors. They were not within the control of the Local Authority.

Q. This is a situation where the Chief Social Work Inspector has informed the Board of Governors that the school would be subject to inspection by the SWSI and that the approach to the inspection would be of a particular type. Can you develop that?

A. This was in a sense moving on from the previous form of inspection of secure accommodation and prior to that, List D schools, which didn't necessarily have a background of standards of care written down that would be expected of these particular units.

What was being developed here was that national standards were in the process of being developed and the Scottish Office's Another Kind of Home, published in 1992, set out the formula by which these standards would be developed and Rossie was simply being told that a more systematic approach to the provision of services

in general and the clearly expressed standards for the conduct of approval, ie, inspection, would take place and this relates very much to, if you like, the forthcoming 1995 Act and the regulations which followed it, in terms of assessing the care plan that children who were placed there had and also the management of that care plan, an integrated care particular and basically Rossie is being informed: well, we are going to look at how you are trying to develop a care plan. You are not simply taking a child in and keeping them in the secure unit. You are actually looking at what sort of additional services you will provide for that particular young person, child or young person, whilst in your care.

Q. And does this relate back to the publication of Another Kind of Home?

A. Yes, that's right.

Q. And the recommendation from the Scottish Office:

"The Scottish Office should review the future needs for secure accommodation following a national inspection ... including an assessment of placements and use, distribution and condition of present provision and the quality of care provided."

A. That's right. They were simply seeking to assess whether the 90-odd places was adequate or not, given

that there was some pressure that perhaps Scotland had too many places.

Q. But the appraisal goes on to focus on the needs and circumstances of the young people?

A. Yes, the standards of care, staff recruitment training policies, external systems of care and support from the Health and Education Services, the complaints procedures, and the current system of management of these institutions.

Q. And we then learn about an inspection carried out by HMI in, I think, December 1992?

A. At Rossie?

Q. At Rossie.

A. Yes, yes, which clearly indicated that they were not particularly happy with the way the head indication was being provided at Rossie.

Q. And there was a concern about the school's management?

A. Concern about the school's management, which in a sense was a sort of entry point into whether or not sufficient care was being provided at a now appropriate level for the young people at Rossie, young boys at Rossie, I should say.

Q. Thereafter, following that inspection was there an SWSI inspection?

A. Yes, that covered 21 pages in detail and this is the

first time I've actually seen such a detailed report on any secure unit and previously a List D school. Extremely detailed. The arrangements for the admission of young people, the fabric of the building, security accommodation, quality of care providing, the aftercare, the views of the young people, which was perhaps new and their parents, the views of social workers, looking at case records, complaints procedure, the physical care of young people, including healthcare and smoking policy, smoking was still permitted of course, the use of segregation rooms, the measures of control and so on.

Q. You list --

A. Yes, that's right.

Q. Certainly compared to reports of yesteryear --

A. It's extremely detailed.

Q. I think we saw -- this wasn't the SWSI -- an inspection report of Smyllum which was half a page?

A. This would not be untypical of that particular period. You can see that there is a sort of stepwise change in the approach to conducting an inspection.

Q. The SWSI report also at 3.2.11 echoed the concerns of the HMI on the unit's management insofar as it affected the integration of education and care?

A. That's right. It's basically pre-dating, if you like, the 1995 Act and subsequent regulations because it's

talking about care planning and programme, including assessment, individual care and the fact that the school simply seemed to be taking the young boys in a rather passive way and not really developing a care plan within the institution itself. Simply the care plan that the Local Authority had.

And what SWSI are saying that once a child is place inside secure accommodation they should have a secure accommodation care plan in addition to any other care plan that the Local Authority might have provided, because the circumstances in that secure unit are different.

Q. You mention the passive role in relation to childcare planning?

A. Yes.

Q. That is compounded by the number of young people who are admitted on an emergency basis for short stays?

A. Yes, yes.

Q. Because that would impact upon how well you could care plan for such individuals?

A. If you have a school such as Rossie, which has a mixture of young people in for a fair length of time and you then have young people coming in almost on the day, that the children's hearing have agreed they should be sent there and there is a place for them, then clearly there

is a management issue surrounding the care planning for one group and the other group.

Q. But notwithstanding these reservations, I think the SWSI report recommended that the unit be approved?

A. Yes, but the subtext is that the Headmaster was planning to retire and a replacement introduced, so that dealt with the management issue, which was fairly usual practice, I'm afraid, where you had a report such as that, which basically criticised its management.

Q. You finish off with Rossie on page 84, 3.2.14. In fact, you tell us that the HM Inspector of Schools had conducted the Rossie inspection as part of the registration of three other secure units, and that's Kerelaw, Howdenhall and High Trees and I think each of the reports for all of these recommended the registration of the secure units?

A. That's correct. I'm afraid the detailed papers surrounding the inspections, I was not able to trace and I think have not been retained, but my assumption is they follow the same pattern of inspection as occurred at Rossie.

LADY SMITH: Professor Levitt, going back to your comment about the Headmaster of Rossie, and you noted he was planning to retire and be replaced, you said it was fairly usual for that to be a way of dealing with

a management issue. Were you also seeing a diminution in effectiveness of heads as they were getting closer to retiring, even though there had not been a problem before?

A. There is some suggestion of that in the reports for the previous decade that I've seen that so and so is due for retirement and they're pulling back. I'm not clear in this case whether or not there was planning to retire was simply and excuse for saying: if you don't retire, you'll be removed.

LADY SMITH: Right.

So if he was at a stage where he could take retirement he would be encouraged?

A. Yes.

LADY SMITH: I just wondered whether there was also an element of an incidence of burnout of people in that role, but maybe it wasn't being tracked at that time?

A. There might well have been, but I think the subtext of SWSI, they wanted a different kind of manager in, who could respond to the new agenda surrounding care planning, personal development, interaction with the Health Services, the Education Services and Local Authority Social Services so looking for someone with a different set of schools.

LADY SMITH: And an appetite for a new way of working?

A. Yes.
LADY SMITH: Thank you.
MR MACAULAY: Do we note at the end of that paragraph that the remaining secure units at St Mary's Kenmure, Rimbleton House and Polmont Youth Care Centre were earmarked for inspection later that year.
A. That's corrects, yes.
MR MACAULAY: My Lady, it's 1 o'clock.
LADY SMITH: I'll take the lunch break now and sit again at 2 o'clock: thank you.
(1.00 pm)
(The luncheon adjournment)
(2.00 pm)
MR MACAULAY: Before lunch, Professor, we were looking at secure accommodation units and we had looked at Rossie.
If I could take you to page 84 of the report, at paragraph 3.2.15, you begin by telling us that the SWSG revised its checklist for the appraisal of secure units in 1995, ahead of an inspection at St Mary's Kenmure; is that correct?
A. That's correct, yes.
Q. And this was under the three-year cycle of inspections?
A. Correct, yes.
Q. And if we read on, I think what you say is the requirements included statements that young people

should be treated as individuals in their own right and be prepared for adulthood. Parents should be aware of the rights and responsibilities, including the right to complain. You provide some further details as to what was to be included.

A. That's right, yes.

Q. If we then turn to page 85, at 3.2.16, you discuss the inspection of St Mary's and, on the face of it, a very detailed inspection.

A. This was the new formula to conduct inspections, which had been, if you like, previewed at Rossie before, but this was the new one coming in and reflected the 1995 Act and subsequent regulations.

Q. Following the inspection, as you tell us at 3.2.17, the SWSI recommended the secure unit should be re-improved?

A. That's right, yes.

Q. I think, as we read on from its report, they clearly identified areas for improvement.

A. Yes, that didn't prevent them from recommending reregistration, but there was clearly an agenda for the management to take on.

Q. And that's developed, I think, on the following page, page 86, 3.2.18. There are particular points mentioned about an unfavourable comment in relation to the harassment of girls by boys?

A. That's right, yes. I haven't seen it before, so this might be a new sort of approach, making clear that the boys and girls -- that the care should be looked at in terms of preventing the harassment of girls in a mixed unit.

Q. This was at a time when the admission of girls to a place like St Mary's was on the increase?

A. Yes.

Q. I think one of the complaints by the girls was that their complaints to care staff were not always followed up.

A. And I think SWSI were trying to ensure that it would be followed up, by bringing this point out, really.

Q. And I think St Mary's agreed to work to implement the report's recommendations?

A. Yes.

Q. That is a standard response, I see.

A. That is a standard response. But, of course, it would be picked up at the next inspection.

Q. Yes. We then move on to look at Kerelaw and, like the other units, it required to be registered and approved.

A. Yes. And there was an issue concerning who would register.

Q. Can you just tell me about that? It's to do with geography, is it?

A. That's right. Kerelaw was in North Ayrshire and was actually owned by Glasgow. And the issue was the North Ayrshire did not think they were responsible for its registration, which it was.
Q. Indeed, I think we know that, because of that, they did carry out inspection.
A. They carried out inspection, which included some criticism of Kerelaw.
Q. If we look at paragraph 3.2.21, page 87, criticisms, for example, around cleanliness, good order, poor care planning, style of accommodation and lack of privacy, as well as low staff morale. So there is a litany of problems?
A. Yes, that's right. Yes, which is interesting because I'd not seen that before.
LADY SMITH: Sorry, what hadn't you seen before, of that?
A. I hadn't seen a local registration authority's report before, so it was quite useful to have that coming in, saying: okay, this is what a local registration authority would do.
LADY SMITH: Thank you. Judging by the list there, there is quite a spread of interest --
A. There's a spread of interest.
LADY SMITH: -- on the part of the Inspectors.
A. Which indicates that at the previous inspection they had

not done so.

LADY SMITH: Thank you.

MR MACAULAY: But so far as the SWSI inspection is concerned, you tell us, at 3.2.22, that that took place in September 2000.

A. Yes.

Q. And follows the same format as the inspection at St Mary's Kenmure?

A. That's right, yes.

Q. Without dwelling on what was said, I think if we look at the last few lines on the page, progress in developing structured programmes of work with young people has been slow.

A. Yes. Again, that indicates that they are working from their pro forma protocol following the 1995 Act and looking very clearly at what in-house programmes Kerelaw had for the young people sent there.

Q. At 3.2.23, on page 88, there is an issue identified there, first of all, in relation to the suitability of the staff and their qualifications; do you see that? At the first paragraph.

A. Yes.

Q. Then an issue about there being a high level of physical contact from the girls towards the male staff; do you see that?

A. Yes. I think it's important to recognise the issue of the quality and qualifications of staff at secure accommodation in particular, where one would assume that the level of staff competence would be required at a much higher level than in other residential accommodation.

And I think that point is bringing out that, yes, Glasgow needs to look very clearly at who it employs at Kerelaw, in particular in relation to the follow point about the risk of abuse towards girls in mixed accommodation.

Q. If we go on to the following page, page 89, at 3.2.25, the SWSI's conclusions, which were about to be published, begins by saying the secure unit is functioning well and young people feel safe.

A. Yes, I noticed that.

Q. Which doesn't fully chime with what has been said before.

A. It doesn't fully chime with what has been said before. And I felt that if you look at it from an independent view, then they recognise some issues and just hope that the management will follow through on the recommendations in the report.

Q. As we are told at 3.2.26, does the fact they would revisit Kerelaw in about 12 months suggest they had

reservations?

A. They had reservations, which they weren't willing to put in print, and the follow-up in 12 months, rather than three years, would indicate that.

Q. You then looked, at 3.2.27, at Howdenhall, and the inspection there in June 1998. I think you told us before, this was a small unit.

A. A small unit, generally used for short term.

Q. Notwithstanding the size, the inspection still lasted a full week?

A. Yes, that's what we would expect, because it would have to go through the same formula as applying to the other units, otherwise they might themselves end up with the criticism that they'd not followed their procedures.

Q. If we move on to the next page, towards the top, that's page 90, at 3.2.28, I think this fits in with one of the comments we have seen previously, that the inspectors noted the standoffish approach adopted by staff.

A. Yes, I would assume that's a similar comment to the issue at Kerelaw in relation to the qualifications of the staff and their ability to actually engage with those that had been sent there.

Q. At 3.2.30, you say that the inspectors were sufficiently concerned about the conduct of units, that they recommended a number of requirements for improvement

should be issued to the Local Authorities that place children.

A. That's right.

Q. Can I understand the reasoning there; what is being said? This is not to the unit, this is to the Local Authorities?

A. I guess what -- they were trying to alert the Local Authorities that if they were sending children there, as a result of a children's hearing or direction of Chief Social Worker, that they should be aware of the need for interdisciplinary assessment. And that they themselves should put pressure on Edinburgh to ensure that particular unit was brought up to scratch.

Q. The comments at the bottom of that page, I think this is a minute from the Assistant Chief social worker Inspector:

"The basic purpose of these inspection visits, to advise on whether the accommodation should be approved, imposes some constraints on the extent to which we can evaluate the effectiveness of the service in meeting children's needs."

So it's a recognition that having regard to why the inspection is being carried out does pose some constraint on, perhaps, a broader type of inspection.

A. And that's -- I suspect, if you like, that is why they

are writing to the Local Authorities who placed children there, to put pressure on Edinburgh to improve the quality of care being provided. It was a sort of round about way of exercising authority on Edinburgh.

Q. There is another warning, I think, to Local Authorities at 3.2.31.

A. Yes.

Q. This is in fact to Edinburgh City, where the message was that whilst the children in the two units were adequately protected and safeguarded, significant deficiencies in care planning had been identified.

So there are two messages.

A. There are two messages and Edinburgh is, if you like, being pressed on two fronts; one is from -- directly the Scottish Executive and the other, the Scottish Executive's hope via the other Local Authorities who were sending children there, who had some responsibility for the children.

Q. There is a sort of pincer movement --

A. A two-pronged attack to ensure that care planning was actually developed.

Q. Again, there is to be an inspection within a year, so once again outwith the normal cycle?

A. That wasn't the normal -- that was outside the normal cycle of three years. There was sufficient concern to

ensure that a further visit would take place to see how far, in fact, the improvements were being implemented.

Q. Do we see in the next paragraph, in fact, that you talk about the follow-up inspection in January 2000 that concluded:

"Although there had been progress in meeting a number of requirements and recommendations, further improvement was necessary to ensure the secure units were fit for purpose."

A. Yes.

Q. So some progress, but --

A. Not enough.

Q. When we read in this section that the HM Inspector of Schools conducted an inspection at the same time; does that mean that the two inspections were taking place --

A. It was an integrated inspection.

Q. That would create quite a large team of people --

A. Yes.

Q. -- descending on the premises?

A. Yes. It would certainly involve three or four inspectors.

Q. And towards the bottom, do we see that the Young Person and Looked-after Children's Division wrote again to Edinburgh Council's Director of Social Work and informed them that as a result of the inspection, the division

remained very disappointed at the continuing lack of completed actions?

A. That's right.

Q. There seems to be an ongoing situation. The Inspector seems to -- not quite bending over backwards, but he's giving a lot of leeway to -- here, we're looking at a secure unit.

A. I think if you look at 2000, the system of secure accommodation is under pressure, as we have seen in earlier cases. And there would be reluctance, I suspect, from SWSI to recommend that the unit should be deregistered. And so long as the council were willing to seek improvement then they should continue, but with a further inspection.

Q. Do we see that really it is the pattern not just here, but in other parts of this area where, rather than come down hard on a provider, the provider's given space to improve?

A. If they felt there was a capacity to improve. And my reading of the file suggests that they believed there was a capacity to improve, but they'd have to continue to apply pressure.

LADY SMITH: And the unit you are referring to here was St Katherine's?

A. Yes.

LADY SMITH: Which was close to Howdenhall.
A. That's right.
LADY SMITH: But you had moved from Howdenhall to St Katherine's?
A. Yes.
LADY SMITH: Thank you.
MR MACAULAY: As is your practice, you give a broad overall view of the section in 3.2.33. As we have discussed, there is a more systematic approach to appraisal of these units.
A. That's right, yes. Which followed from the Scottish Office publication, Another Kind of Home, and the White Paper, in 1993, on Scotland's Children Proposal for Childcare Policy and Law. And, obviously, the checklist that was developed in 1995, and the issues surrounded, I think -- which was different from an earlier period -- managing throughcare within the particular units.
Q. Your next section is headed:
"Inspections and inquiries on issues of special concern."
Over the period 1995 to 2001. You indicate where you're going to go with this. The first is to do with lack of availability, and we've looked to some extent on that already.
A. Yes.

Q. The second concerns issues that arose on the establishment of new provision, and I think that's dealing with The Elms in Dundee?
A. That's right, yes.
Q. And the third concerned inappropriate behaviour by a member of staff.

If I can look at these areas briefly. First of all, the availability of secure accommodation over the period 1995/1996. This brings back to mind the case of the boy who had been murdered in Dundee --
A. That's right, yes.
Q. -- and the difficulties associated with his being placed prior to the crime happening.
A. That's right, yes, yes. You can see here the discussions that went on in relation to ongoing professional thinking about any kind of residential accommodation, including secure units and, if you like, the political pressure that was applied to increase the number of units/spaces available in Scotland.
Q. And I think we've looked already at what has been reported to have come from Ministers and their expressions of surprise, really, that such a situation should exist.
A. They had been given assurances that the number of placements in Scotland was adequate.

Q. We touched on this already, but there was a report on secure care, which I think was now published; is that right?
A. That's right, yes, yes.
Q. Was the upshot here an increase, but not a large increase of the places available?
A. Not a large increase. And I think it had been -- what had been proposed was reduced in scale, but was still an increase over what it had been before, and so instead of 90, there should be somewhere between 90 and 100 beds available in Scotland.
Q. Then we look at 3.3.9, and that's the provision of a secure unit in the period 1998 to 2001. This was in response -- at 3.3.9 -- to the report on secure care.
A. That's right, yes, and the fact that the boy that had been murdered had been murdered in Dundee, where there was an issue of availability of secure accommodation, even on a temporary basis.
Q. What we see is that the unit that was being proposed was again a small unit, consisting of a five-bed closed support unit and a three-bed secure unit?
A. Yes.
Q. So, from the secure estate's perspective, it's three other places?
A. Three additional places, yes. Within a continuum of

care, close support did not imply the level of supervision that secure unit would have.

Q. If we turn to paragraph 3.3.11, towards the bottom of page 95; do we see here a reference to a formal joint inspection by SWSI and HMI was conducted in June 2000, once the work had been completed, and essentially concluded that the new build accommodation was fit for purpose?

A. Yes.

Q. Although I think we see later on that there are issues --

A. Issues emerge when children began to be placed.

Q. I think that was in June. Do we see, at paragraph 3.12, that there were a series of critical articles in the press about Dundee City's residential units? How does this fit into this particular narrative?

A. I think from what I gathered, the City were concerned of the criticisms being levelled against its ability to deal with the particular cases, particularly the existence of child prostitution in the city, and that the lack of secure care had meant there was no available places and they could not be accommodated in secure units for their own safety.

Q. You mentioned, and indeed you mentioned the extent of child prosecution in the city, and I think the same

press --

LADY SMITH: I think child prostitution.

MR MACAULAY: Prostitution. In the city, and I think the same press reports talk about violent youths roaming the streets?

A. Yes, yes, yes, at that time.

Q. In any event, the secure unit, you tell us, was opened in December 2000, but then problems emerged?

A. Problems emerged on the management of the unit, in terms of safety to the young people who had been placed there. And the issue related again to staff training. There was only one member of staff trained in the appropriate procedure.

Q. Was the response from Dundee City Council essentially to intimate that the unit would be closed and they would seek to implement an action plan to correct the security issues?

A. That's right. They closed it ahead of any deregistration of the unit.

Q. If we turn to 3.3.16, page 97, we can see that there was another joint inspection by SWSI and HMI Inspector in November 2000? And this, so far as one can read, produced a positive response.

A. Yes. Clearly, they intended to interview everyone involved, including from the Local Authority, Building

and Finance Officer, Education Department, Head of Behavioural Support Services, as well as those within the unit itself.

They clearly thought it was a positive move, four secure beds, plus five close support beds, the latter having remained operational throughout the period. It was only the secure unit that had been closed.

Q. We read on, at 3.3.18, subject to an action plan by Dundee City Council, the unit was considered fit for purpose, and that was confirmed by the Scottish Ministers?

A. That's right, yes.

Q. Now, the next heading is:

"Rossie School, the allegations of abuse and the standard of care."

This is 1997 to 2001. The submission that you quote from, at the top, contains positive messages.

A. It does, yes, yes. Evidently, they felt that Rossie had moved on with its new senior manager.

Q. This is in August 1997?

A. Yes, yes.

Q. Although there are some reservations. For example, better access to psychiatric services should be secured, take that example.

A. That's right. I think it's important to recognise that

at ministerial consideration of this report -- and evidently the report was sent to Ministers -- that the school should be inspected twice a year, with one of these being unannounced. And that's a new departure.

Q. But not long after, three months later, the SWSG learnt through the press that there had been allegations of child abuse, drug and alcohol abuse, and illicit sexual activity at Rossie and that set off a train of events.

A. A train of events to investigate the veracity of the allegations.

Q. I think there was an inspection -- if you look at 3.3.23, page 99 -- over two days, in January 1998.

A. Yes. SWSI, and that was followed up by the Health Department's Medical Officer.

Q. Can you tell me what the outcome was then of the --

A. There was clearly an issue surrounding the internal management of the secure unit and that the segregation room had been used extensively over the period January to August 1997, compared with the previous six months.

And although there were positively developments, there needed to be a clearer strategy for a reduction of the use of single separation. That's within the secure unit itself, the young people being segregated from each other.

Q. And if we look at 3.3.25, do we see there the quote from

the report:

"Rossie staff and governors do not believe they have a serious drug problem ..."

A. That's right.

Q. Was there any evidence of a serious drug problem?

A. They evidently did not believe there was, and that SWSI supported Rossie on the basis of the evidence that -- and the police reports that they had, that there wasn't a significant drug problem at Rossie.

Q. If we go to paragraph 3.3.28, this is another unannounced inspection by SWSI in November 1998, and can we read there that they found no grounds for concerns about the safety of the young people at Rossie:

"The young people spoke positively to inspectors about the care they received. Since the last inspection there had been progress in improving the quality of education and work with Local Authorities."

So that's a positive description.

A. Yes. I think it's important to bring out the fact that this was an unannounced inspection, ie, the inspectors simply turning up. And this follows the Ministerial direction earlier, that there should be two visits, at least one unannounced.

Q. Just going back to, I think, one of the allegations that was being made at 3.3.30, on page 102; can we see that

SWSG was informed by the Crown Office that there were proceedings against an ex-member of staff for assault?

A. That's right.

Q. Was this essentially in connection with what one might describe as overzealous restraint?

A. It would appear to be the case. I was not able to establish any further proceedings in the court case.

Q. We don't know whether there was a conviction or not?

A. No.

Q. Then we have another inspection with SWSI and the Health Department's Medical Officer, and the HM Inspector, in September 1999. So they're keeping a close eye on this establishment?

A. Yes. It's a big establishment and there's obviously some history attached to Rossie and the Minister is clearly aware of it, and that's why the Minister insisted that there should be regular inspections, with some unannounced.

Q. I think positive messages come out of this inspection. If you look at 3.3.34, the SWSI inspectors commented that the young people at Rossie feel safe and settled; is that correct?

A. That's correct. Although there was a caveat attached to the end of it, in terms of the segregation suite.

Q. The segregation suite seemed to have been a problem at

Rossie, that it was -- as we're told, it wasn't very attractive.

A. No, no. Cold, dirty, smelly and worse than a police cell, were the comments.

Q. Also, we're told, I think, that young people who had to face that often had to be carried, sometimes struggling, down several flights of stairs and through a number of doors.

A. Yes.

Q. Thus endangering their safety.

A. Endangering their -- it wasn't the purpose of Rossie in the first place.

And that they should replace the segregation unit.

Q. I think the messages they were getting from the children, but being locked in their own rooms might be a better option for that.

A. Yes.

Q. Professor, you have a general review of what we've been discussing, at 3.3.36. Perhaps you can just summarise, give us an overview, as to what you say?

A. The three issues, the availability, suitability, small-scale provision, allegations of abuse, illustrate, really, that the SWSI's inspectorial functions went beyond its three-year cycle. It was clearly some continuing concern that young people were being placed

in secure accommodation and its suitability for them, in terms of the care planning and personal development.

It had to accept that the decisions on placements were made by the Children's Panel, Directors of Social Work and even by the Secretary of State and Scottish Ministers.

And I think what is evident from these reports is there is a very cautious approach by the inspectors. They knew they had to have secure accommodation, but at the same time there were continuing concerns on the quality of provision that was being supplied and offered to the children in these particular units.

It meant that they stressed the issue of staff training, and particularly trying to ensure focused integration of social, educational and healthcare within the personal development plans for each young person who had been committed there.

In addition, there were clearly ministerial directions, and that required, in order to implement them, considerable fresh and professional tact, and repeated appraisal of provision to ensure that the Minister's directions were being followed.

Q. Then there is a relatively short section, 3.4, on page 104, headed:

"Review of secure accommodation."

1998 to 2003. What you are seeking to capture in these two or three pages that you devote to this?

A. What I think the report is trying to bring out is the fact that it was clearly evident that secure accommodation was required. There were clearly issues concerning the young people concerned. Over 80 per cent had offended in the community, a third had deliberately harmed themselves, two-thirds had problems in relation to drug and/or alcohol abuse, and half the girls and a fifth of the boys were thought to have been sexually abused so there were clearly complex issues there, requiring more specialist provision.

In addition, there were issues concerning psychiatric or psychological care that was required. There were clearly distinct problems and distinct issues that required highly specialised support, and I think that's what these reports bring out constantly, saying that you've got to make sure the agencies are working together, even within the secure units. And secure units have the highest possible level of professional skills available within them.

Q. I think SWSI in this connection had commissioned a survey of young people in the secure accommodation themselves --

A. Yes.

Q. -- to see what their position was; did that produce a report?

A. There were evidently ongoing concerns about the use of secure accommodation in Scotland, and that as a result the Minister for Education and Children established an advisory group to advise on the future development of the estate. In particular, the issues surrounding Kerelaw, whether it should be replaced or not, the financial support and further investments, in terms of secure accommodation and the specialist programmes that were required within those particular units.

And, in particular, I think it was noted that there was more evidence of young girls, particularly, requiring care and assistance. And I think that's the difference from an earlier period, and that the provision did not -- as it existed, did not necessarily represent the needs of that particular group.

Q. I think there was a group set up, the secure accommodation advisory group, SAAG --

A. Yes.

Q. -- to look into this issue?

A. Yes. And their view is: okay, yes, we lock up a much higher proportion than England and Wales. Girls need a third of the places. The current demand, irrespective of disproportionate between -- south of the border is

certainly more than we are actually providing. 83 to 139 suggests something in the region of 100 plus places ought to be provided.

There are clearly some differences between the Local Authorities in terms of needing secure accommodation. But, in relation, there is nothing that central Government could do about that, because placing children in secure accommodation was really outwith the current set of regulations or current legislation.

It noted that, yes, future developments should surround specialist units from girls.

Q. Do we learn, at 3.4.6, that in October 2002 the Minister announced that the Scottish Executive was seeking to increase secure accommodation by 24 beds?

A. Yes.

Q. That is a larger increase that we'd seen previously.

A. Yes, and that reflects the fact that they've begun to accept that specialist provision for young girls was actually necessary.

Q. If we look at the next section in the report, at 3.5, you have a section here headed "Joint inspections", 2002 to 2005; can I just understand fully, just in case I'm misunderstanding what is meant by "joint inspection"?

A. "Joint inspection" refers to the institution of the Care

Commission, and within the regulations, the Care Commission, it was intended that they have the responsibility for the inspection of secure units of accommodation.

The issue that I think this particular section tries to bring out is the fact that they didn't have enough skilled staff to conduct the inspection, so they continued to rely on the Social Work Inspectorate actually beyond 2005.

And the issues that concerned that, in particular, in relation to some of the joint inspections that emerged in that particular period.

Q. Just looking -- I think we have looked at this earlier, but just to remind ourselves -- in relation to the jurisdiction then of the Care Commission, from an inspectorial perspective; what was that jurisdiction?

A. They had -- they took over the responsibilities of the Social Work Inspectorate to inspect and make recommendations for improvement or to recommend to Scottish Ministers deregistration.

But if I could add, of course, that deregistration would, first of all, go through to social work inspectors and then to administrative officials within the Scottish Executive. It's not a question that the Care Commission was simply sending a letter, detailing

the circumstances, direct to a Scottish Minister. It would go through an appropriate process inside the Scottish Government at the time.

Q. The first joint inspection you mention at 3.5.2, we're back to The Elms in Dundee, in June 2002.

A. Yes.

Q. Now, just let's note, as you point out, that the SWSI, the HM Inspector of Schools, was assisted by the Health Department and the Care Commission for this joint inspection.

A. Right. But you must remember the Care Commission were established in April 2002 and, therefore, within the regulations, had the responsibility for conducting that. But it was decided that they didn't have enough specialist staff and, therefore, "We'll carry on as we are, and they'll come along and tag along and perhaps appreciate and learn and how to inspect secure accommodation", as opposed to ordinary residential care accommodation; does that make sense?

Q. It does. Thank you.

So far as this joint inspection was concerned, we read towards the bottom of that page, 108, that a particular strength were the assessments of risk young people posed to themselves and others. So that's a positive note?

A. It's a positive note, with a caveat.

Q. Yes:

"Although there was ample evidence of one-to-one work between key workers and young people, this tended to focus on daily living rather than the reason for admission and we have already identified the requirement for the unit to develop multi-disciplinary assessment of young people's needs and more formal programmes of work."

So you are right, you give with one hand and take a little with the other.

A. Yes, it's being positive, but stressing again, if you are, like, following the 1995 Act, the need for multi-disciplinary interagency approach in developing and implementing an individual care plan.

Q. So far as Rossie is concerned, at 3.5.6, you tell us that the first joint inspection -- page 109 -- under the new post-2001 arrangements was in September 2002.

A. Yes.

Q. Again, we read that the school has made progress in promoting aspects of positive behaviour among young people. So we have -- we begin with that positive message?

A. It's the same themes emerging, the need for structured programmes, structured care programmes within the unit

itself.

Q. If we look at the top of page 110, the shortages of teaching staff have hindered the implementation of a broad and balanced curriculum?

A. Yes, yes.

Q. But since the last report, the last approval inspection, in 1989, specialist services had also been introduced, including a mental health initiative. Then do we have this practice of action points being set out for --

A. Which is relatively new, that the inspections would lead to some commendations as to progress, but then action points that would be required to be followed up, and would be appraised at the next inspection.

Q. This report, I think, was issued in August 2003. But the following October -- which would be August 2004 -- the SWSI and the now entitled HMI of Education, assisted by the Health Department's Medical Officer undertook a follow up inspection, to evaluate progress on the recommendations made; what was the outcome here?

A. It was, again, indicating that there had been progress, although there were clearly incidents of parasuicidal behaviour of some people. No serious outcomes. Senior management should review their cases, the robustness of risk assessment and risk management, and the appropriateness of immediate actions taken.

So that was positive.

Less positive was the implementation of focused programmes of work. It wasn't necessarily related to each individual child and, again, the issues surrounded staff training to implement child assessment.

Q. The next joint inspection you draw attention to -- at 3.5.11 -- is of St Mary's Kenmure.

A. Yes.

Q. That was in October 2003. Can we see the inspection team now is the SWSI Inspector, three HMIs of Education, Health Department Senior Medical Officer and a member of the Care Commission.

A. That's right.

Q. Again, quite a group.

A. It's quite an integrated inspection. And with three HMIs of Education, it indicates the seriousness to which education provision was being evaluated.

Q. And this, the intention behind this inspection, was to see whether the Scottish Ministers could approve the --

A. Yes, continue to approve.

LADY SMITH: That is six people in the team, I think? Is that right?

A. Yes, yes.

It was the same social work Inspector since 1995, throughout this period.

LADY SMITH: Right. In every one of these inspections?
A. The same particular Inspector.
LADY SMITH: How interesting.
A. He'd obviously been assigned to that particular -- that particular Inspector also generally did deaths in care.
MR MACAULAY: Yes.

This inspection found that progress had been made in relation to the previous inspection in 1999, most notably in establishing a programmes team and providing specific input to meet the assessed needs of young people.

Again, we see here that it's a positive result and that the approval by Scottish Ministers should be given?
A. Yes, yes. Clearly, they felt that St Mary's Kenmure had improved the quality of its provision since the previous reports.
Q. The next joint inspection is of Howdenhall and St Katharine's, and this was in June 2004.
A. Yes.
Q. A large inspection team, again.

If we turn on to page 112 in the report, they noted improvement in the methods of assessment of young people, and the integration of health issues within their care plans.

This next sentence:

"However, on the advice of the Scottish Executive Officials the SWSI's involvement had required the special approval of the Scottish Ministers."

What is that telling us?

A. Well, that simply reiterates the position from April 2002, that the inspection was meant to be led by the Care Commission and that, as I say in the following quote, the legal basis for Ministers to register was a quality of service. There was no longer any legal basis to ensure the quality of service. Basically, it was the quality of buildings, rather than quality of service. That had been delegated, if you like, to the Care Commission and, therefore, there was, if you like, a constitutional issue surrounding the registration.

But, if you like, the upshot was everyone forgot about it. And would carry on, on the basis as previously.

Q. I think the last joint inspection that you consider under this head is of Kerelaw.

A. Yes.

Q. I think we have seen before that there had been concerns about Kerelaw, partly in relation to the physical conditions of the buildings and also to the extent of staff training and the programme of care provided, especially to girls.

Now, Kerelaw was clearly suffering problems.

A. It was evidently suffering issues which -- and it would appear that Glasgow City Council no longer wished to maintain the school as -- for secure accommodation, and wished it to be redeveloped for other purposes, childcare purposes, looked-after children care purposes.

Q. I think, essentially, it was clear that some investment into Kerelaw was essential.

A. Yes, yes, yes.

Q. Because of the situation there, we are told, just above halfway:

"That since local government reorganisation, Kerelaw has suffered from low staff morale and poor management."

In that context, Glasgow City Council wished to see it redeveloped in an up-to-date building to reflect the authority's commitment to high-quality care.

A. That's right.

Q. That was the council's position then.

A. Yes.

Q. Do you tell us, at 3.5.16, that in November 2003 there was an integrated inspection of Kerelaw by HM Inspectorate of Education and the Care Commission, and the resulting report commented unfairly on the school's --

LADY SMITH: Unfavourably.

MR MACAULAY: I'm sorry, unfavourably on the school's management.

A. Yes. I think it's important to realise that it's the first integrated inspection that I've been able to find between HM Inspectorate of Education and the Care Commission, without the Social Work Service Inspectorate.

Q. Is it called "integrated" because it's no longer joint?

A. Yes, yes. "Integrated" because the Care Commission are an arm's length Government body, so it can't be called "integrated".

Q. It can't be called "joint" because they are the lead; is that the way it works?

A. Sorry, they -- it's an integrated inspection, rather than a joint inspection, because it's -- they're no longer -- the Care Commission is not officers of Scottish Ministers.

Q. I think the upshot of what was a negative report was that Kerelaw was required -- and I assume this is Glasgow City -- to prepare an action plan addressing the main findings.

I think as we discussed before lunch, this seemed to be the procedure; if there were negative findings, then the provider was allowed time to put together an action plan to meet these findings?

A. Yes, and Glasgow was given an action plan, but in the process of considering the action plan there were allegations against members of staff, a police investigation, and a further HM Inspectorate of Education and Care Commission inspection, which resulted in an improvement notice being issued by the Care Commission, which I think is the first one that I've come across in relation to secure accommodation.

The end result was that Glasgow City Council decided to close Kerelaw's open school and enter into discussion with the Scottish Executive about transferring secure unit young people to other providers.

Q. I think that's what happened, is it?

A. Yes, yes.

Q. Then you have an overriding review of the chapter we have been looking at; can you briefly summarise that for us, Professor?

A. Yes. It seeks to indicate that at the beginning of the period of review there were 84 places divided among a number of units; three large units and a number of small units.

Small units were essentially for short-term placements, and restating that they were subject to inspection by SWSI, before approval of the Secretary of State.

Rossie and St Mary's and Kenmure were also subject to improval by the Secretary of State as residential establishments for the purposes of secure accommodation, and the inspections by HM Inspector of schools.

There was clearly a shift in thinking in terms of what kind of care should be provided in secure accommodation, publications of Another Kind of Home, and then the White Paper, Scotland's Children's Proposal for Childcare Policy In Law, ahead of the 1995 Act. That Act and the subsequent regulations brought out the need for moving on from, if you like, the best interests of particular young people who had been placed there to integrated plans for their care and development whilst they were there.

Effectively, the inspection reports subsequent to 1995, right, all were beginning to stress the need for integrated care planning, involving three services, social work, education and health, given the needs, the complex needs of the young people that had been committed there.

Clearly, the inspections were not necessarily all extremely positive. There were some which required action, and action points were laid out and were subject to review increasingly -- increasing number of inspections that followed after the short term. So,

within the three-year cycle of inspections, there were other inspections taking place. So it can't be said that in this particular period, at the end of the period, that there wasn't very close inspection taking place of secure units of accommodation.

LADY SMITH: Professor Levitt, did all these reports, that you're referring to here, speak with one voice or could you tell from the way the report was written which part was Social Work Services Inspectors and which part was HMIE?

A. Sometimes there were separate reports.

LADY SMITH: I wondered about that.

A. Sometimes there were separate reports. But, generally, the report, I think, went through SWSI. The Medical Officer, sometimes had a separate report, which was incorporated in.

My guess is that the eventual report was looking to endorse Social Work Services Inspectorate's review by saying two linked professional bodies, in education and health, also support the view of Social Work Services Inspectorate in the recommendations being made. So it's not simply a social worker making a recommendation. It's an HM Inspector, Education Inspector, and a Medical Officer, Senior Medical Officer.

I think the person conducting on the medical side

was a Senior Medical Officer within Scottish Government at that time.

It had an additional force.

LADY SMITH: Thank you.

MR MACAULAY: Yes, I should say sometimes there would be separate reports, because on occasion you will see in a report reference to other reports that have clearly been produced separately.

A. Yes.

Q. Do I take then, from this discussion, that the only secure unit so far to fall by the way side is Kerelaw?

A. That's right.

LADY SMITH: Mr MacAulay, it is 3 o'clock. I would usually take a break. Would that fit with your plan?

MR MACAULAY: Yes.

LADY SMITH: We'll take a short break and get back to the rest of your evidence for today, Professor.

(3.00 pm)

(A short break)

(3.10 pm)

LADY SMITH: Professor Levitt, are you ready to go?

A. Yes, thank you.

LADY SMITH: I mean "go" in answering more questions. I will let you away at 3.45.

Mr MacAulay.

MR MACAULAY: Professor Levitt, if we move on to section 4 of your report, you have a general heading of "Residential schools". The first section you look at, 4.1, is devoted to independent grant aided residential schools for children with special educational needs.

I think what you repeat here, really, is that the residential schools with special needs resided with HM Inspector of Schools; is that right?

A. That's correct, yes.

Q. As far numbers are concerned, within that group, there were just under 40 such schools in, I think, 1996?

A. That's correct. That's the figures I could actually establish.

Q. You go on to say that the 1980 Act, Education Scotland Act 1980, defined an independent school as:

"A school at which full-time education is provided for five or more pupils of school age, not being a public school or grant aided school."

That is the definition from the Act.

A. Yes, that's right. Yes.

Q. Now, you go on to look at, I think, eight schools that fall into this category, beginning with Raddery and that's at page 11.9, at 4.1.4.

You say that Raddery came to the attention of the Joint Parliamentary Under-Secretary of State because

there had been allegations of sexual abuse there, and you set out what the information available then was.

A. Yes, that's correct.

Q. The school, you tell us, had been established for:

"Emotionally and disturbed children, aged 9 to 17 and, like other independent schools, required to be registered with the registrar for independent schools."

A. Yes, correct.

Q. What was the response then to the allegations that were being made?

A. The response initially was to await what action might be taken by the Procurator Fiscal and the member of staff was charged later by the police and released on bail. The Minister was then informed by the SED that two former pupils had complained about this particular member of staff, and the HM Inspector of Schools was making arrangements to conduct a full investigation of the running of the school on behalf of the Secretary of State, under section 99 of the 1980 Act, as a matter of urgency.

Q. Do you tell us, at 4.1.8, that previously, in November 1992, and after a visit by the HM Inspector of Schools, a set of recommendations had been made to improve safety and the standard of care?

A. That's right, yes. That was an ordinary inspection,

which followed from a series of incidents. These included the requirement that staff -- further staff training and permissible forms of physical control and constraint, formal complaints procedure for pupils and an element of outside independent involvement, staff development and appraisal should be introduced.

Q. A number of recommendations were made, but I think we're told that these had not been fully implemented?

A. That's correct, yes, yes. That included a formal complaints procedure not being established.

Q. If we go on to 4.9, I think you tell us that the full HM Inspector of Schools inspection was completed in 1993, and I think this was quite a positive report?

A. It was relatively positive, in that they'd made substantial progress to meeting the recommendations previously set. And a further visit indicated that further progress had been made, so there was a series of inspections as a result of incidents and concerns at the school.

Q. Do you tell us, at 4.1.10, that in September 1994 the ex-house parent was found guilty of indecent practises towards five girls under the age of 16?

A. That is correct. So, clearly, the concerns had resulted in a charge and, also, that there had been HMI inspections.

Q. Did allegations of inappropriate behaviour then emerge again in 1995?
A. It did, yes.
Q. And what was the response to this?
A. The HM Inspector of Schools informed the registrar of independent schools and there were other -- there was additional evidence of other incidents which had given concerns.
Q. But do you tell us, at 4.1.12, on page 123, that Raddery's reaction was the production of an internal report?
A. Internal report, which was not seen as adequate by the Schools Inspectorate and that there remained issues of concerns for child protection.
Q. And the HM Inspector of Schools is quite critical of this as an approach to the allegations that have been made?
A. That's right. In fact, although it says HM Inspector of Schools, in fact that was in fact the Senior Inspector of Schools at the time. So it was taken to a very high level, informing the chair of the governors that they ought to institute child protection procedures as previously outlined. And that a further inspection would take place.
Q. I think you discuss that inspection at 4.1.15?

A. Yes.
Q. And it appears to have been a fairly thorough inspection.
A. It was a very detailed inspection, which I think you can -- you note it involved the Assistant Chief Social Work Inspector, and that was someone, if you like, at number two rank within the Social Work Inspectorate.
Q. Do we learn in the report that the allegations were against the ex-principal and spread over a period of 16 years?
A. That's right, but it wasn't thought -- the Fiscal didn't believe criminal proceedings would be instituted because of the historic nature and the vagueness of the evidence; all right? Although there was sufficient evidence to indicate that the principal had used inappropriate physical sanctions on a number of occasions.
Q. Then, on page 125, 4.1.17 to 4.1.18, do we see that further incidents emerged?
A. Further inappropriate behaviour occurred and HM Inspector of Schools sufficiently concerned that the -- to attention of the police, and the Secretary of State would have to be advised about the possibility of issuing a note of complaint.
Q. And the issues here were, I think, to do with a deputy

principal?
A. That's right, yes.
Q. And it's physical abuse?
A. That's right, yes.
Q. Kicking and ...
A. This and two other incidents confirmed. The effectiveness of the procedures that had been introduced as a result of previous inspections and HM Inspector of Schools writing to the Board of Governors.
Q. I think the person involved was given the option of dismissal or resignation, and he chose to resign?
A. That's right, yes.
Q. The next school you look at is Oakbank School in Aberdeen, the period 1993 to 1995.

I think you say Oakbank had been a List D school?
A. Yes.
Q. But it was now providing education for up to 66 pupils of secondary age who had pronounced social, emotional and behavioural difficulties; is that right?
A. That's correct, yes.
Q. And, like Raddery, it was an independent residential school?
A. It was an independent residential school, which required registration with the Registrar of Independent Schools.
Q. I think the problem that arose here was a local

councillor complaining about several staff at the school, and one staff member in particular had previous convictions?

A. Yes, 13 previous criminal convictions, including indecent exposure. The member of staff had admitted the crime, but the criminal records office in Glasgow revealed no trace, so the particular person continued to be employed.

Q. As we read on, one way ahead was for there to be an HMI inspection, that was seen as a sensible way ahead with SWSI assistance.

A. That's correct, yes, yes. But there were issues connected with a joint inspection, because of the difference in legislation.

Q. So what happened?

A. The HMI Schools Inspectorate would conduct the inspection with the assistance of the Social Work Inspectorate.

Q. Do we see, at 4.1.25, on page 128, that that inspection was completed in January 1995, and the outcome in the report was that the overall performance of the school was unsatisfactory, with serious failings in the standard of care provided and a worrying breakdown of discipline?

A. Yes.

Q. What was the upshot here?
A. The upshot was that there was a clear grounds for notice of complaint being issued against the school, but the advice from HMI to the Secretary of State that no action should taken, but the school should be given an opportunity to implement an action plan it had set out for the school.
Q. I think this is the pattern we've discussed already, that this seemed to be the way that these problems were being addressed?
A. It gave the management time to reconsider its system of management, and there would be a further inspection at some time to affirm that the action plan had been implemented.
Q. Next school you look at is the Camphill Rudolf Steiner School in Aberdeen, in the period 1994 to 1996. This school was also, I think, an independent school like Raddery and Oakbank; is that right?
A. Yes.
Q. It was required to register with the registrar?
A. Yes.
Q. And there was an HM Inspector of Schools inspection with the assistance of the SWSI in late 1994; is that correct?
A. Mm hmm.

Q. I think there were two incidents which may have been the background to this inspection, and these involved the removal of a child by Highland Regional Council after two members of staff were suspended and charged with an incident involving tying up of the child, and also allegations of rough handling?

A. Yes, and the inspection was focused on any deficiencies in the practice of care at the school and inappropriate provision for the pupils at the school.

Q. There is a separate allegation that a mother removed her daughter, alleging she had been raped in the school grounds.

A. That's right, yes. But this wasn't followed up in terms of HM Inspector of Schools.

Q. The outcome of the investigation of the -- I think, first of all, at 4.1.28, there was some consideration -- the HM Inspector of Schools was asked to investigate and the investigation lasted 14 days?

A. Yes, that's quite a long period of time, two weeks, with the assistance of a Social Work Inspectorate, again because the difference in legislation.

Q. And what was the outcome?

A. The outcome was that the recommendations were made and there would be a follow-up inspection.

The Scottish Ministers were advised there were no

grounds for a notice of complaint given the very specialist provision that Camphill provided, and that a follow-up visit by the Chief Social Work Inspector accompanied by another SWSI Inspector, indicated that they were impressed by the school's integrated approach to care, education and therapy.

I think it's important to bring out that it was the Chief Social Work Inspector who visited, not just an assistant or an ordinary Social Work Inspector.

Q. That was a visit in September 1995?

A. That's right, yes, and another follow-up inspection by the Inspector of Schools were indicated that a designated child protection officer and other procedures had been instituted.

LADY SMITH: Can you just flesh out for me your feeling that it was important to stress that it was the Chief Social Work Inspector himself, I suspect, who visited?

A. Yes, yes. The previous cases, it was an Assistant Chief Social Work Inspector, ie, the Inspector who held the brief for all childcare at that time and had for other inspectors under their management.

In this case, the Chief Social Work Inspector decided to visit.

LADY SMITH: And that's not very common?

A. I haven't come across it. In all the other inspections,

it is either the Social Work Inspector and some times, if there is a serious issue, the Assistant Chief Social Work Inspector.

LADY SMITH: Why, in this case, do we find the Chief Social Work Inspector leading it?

A. I think by 1995 there were serious concerns in residential schools and this is the third case, if you like, that had come up. Camphill, a Rudolf Steiner School was clearly thought as a very specialist provision and, therefore, the attention of the Chief Social Work Inspector to reassure the Inspectorate and Ministers I think was regarded as important.

LADY SMITH: So we are getting a tension here between, on the one hand, being desperate not to lose the specialist provision that the Rudolf Steiner School could afford -- because nobody else was offering that -- but, on the other hand, recognising there was a real problem with the allegations, with the failures that were occurring in the school, and that needed to be addressed, or the answer had to be: enough, no more?

A. The answer had to be addressed, otherwise the recommendation for deregistration under a notice for complaint would have been issued.

LADY SMITH: Thank you.

MR MACAULAY: Just on that line, I think part of the remit

for the inspection was to -- whether or not they would have to consider serving a notice of complaint.

A. That's right, yes.

Q. But it's made clear in the report that there were no grounds for such --

A. There were no grounds. They were satisfied that the school had instituted enough remedial measures to avoid that.

Q. You then go on to have a short section on Stanmore House in Lanark, in 1996, 1998, that is 4.1.32, on page 131. That's another example of the SWSI assisting the HM Inspector of Schools with an inspection and this was in September 1997?

A. That's correct, yes.

Q. This school, you tell us, was managed by Capability Scotland and, again, it was catering for children with complex learning and physical difficulties. It was seeking registration with the Local Authority under section 34 of the 1995 Act; that's what you tell us?

A. That's right, yes. The inspection was led by the HM Inspector of Schools with some assistance from the Social Work Inspectorate.

Q. At 4.1.33, you indicate that the inspection lasted a full week?

A. Yes.

Q. So, again, a thorough --
A. A thorough inspection, with the Social Work Service Inspector visiting the school for two days.
Q. As you tell us in the last section, in this part, 4.1.34, although they were described as minor comments, the HMI Inspector's report was generally supportive?
A. Yes, yes.
Could I add that these four cases were really the only cases I could uncover from the retained files dealing with that specialist independent school.
LADY SMITH: Thank you.
A. Which I don't apologise for, but that's all I could find. There might have been other cases.
MR MACAULAY: The next school you look at is Donaldson College, that used to be in Edinburgh and I think it's moved.
A. Yes.
Q. But this is another residential school where, in 1998, the HM Inspector of Schools was assisted by the SWSI, and the college, you tell us, was an independent grant-aided school and provided nursery, primary and secondary education for pupils throughout the UK.
A. Yes.
Q. Essentially, although the pupils may have had other problems, essentially it catered for pupils who were

severely or profoundly deaf?

A. That's right.

Q. Now, in 4.1.36, on page 133, there was an allegation of rape concerning two of Donaldson's pupils, which allegedly occurred outside of the grounds of the school; did that result in the Board of Governors conducting an internal inquiry?

A. Yes, which the SOED thought or believed had acted with complete proprietary, full co-operation with the police, and the female pupil was offered counselling.

The Minister was informed -- it was obviously in the press at the time -- that in the light of other recent occurrences, presumably at Camphill, Raddery and Oakbank, this minute was put forward, but it was not of the same order, did not involve school attendance and was really a matter for the police, rather than the Education Department.

Q. In relation to Donaldsons; were there also allegations made against the Headmaster?

A. Yes, later, the Highland Regional Council informed the Education Department two boys -- on two boys they had placed in the school, the Headmaster had stated -- in a drunken state, had wandered into the bedroom apparently singing and talking nonsense. There seemed to be some difficulty within the school about pursuing the

complaint.

In addition, the headteacher had entered the girls' bedroom and Regional Council believed the girls were under 16 years of age, their education authority ought to be informed, and the usual child protection procedures set in train.

Q. There was no suggestion of sexual abuse at that time?

A. No, no, there weren't.

Q. But there was an allegation by a female student suggesting that, at Lochgilphead Outdoor Centre, she had been raped by the Headmaster?

A. That's right, yes.

Donaldsons suggested the Scottish Office carry out an investigation and they apparently believed that they would, like Camphill, come out of it quite well.

The Education Department official advised that it wasn't really a matter for the Minister and not for inquiry.

Q. Was there an inspection of Donaldson in April and May 1998 and you talk about that at 41, on 46.

A. Yes. It was evident that there was some concern within Edinburgh and Lothian's Child Protection Committee on Donaldson. It's not clear what other evidence they had obtained. They were concerned that the school had not registered or sought registration with them, as it

should have, under the 1995 Act, and had not engaged with the City's child protection programme.

Q. Then the inspection, in 1998, do you tell us that the HM Inspector of Schools were accompanied on this occasion by an SWSI Inspector?

A. Yes, again that format, the difference is in the legislation, and it was assisted by the Social Work Inspectorate, and it transpired as a result of that -- further allegations against the Headmaster, who after the HM Inspector of Schools had talked to the governor, the Chair of the Governors was suspended.

Q. If we look at 4.1.49, page 139, do you say that the inspection report published in June 1998 made a series of recommendations on strengthening the school's child protection procedures?

A. Yes.

Q. And that would be through the development of a personal safety programme for the pupils, and a more child and parent friendly complaints procedure?

A. Yes, they should institute, basically, Edinburgh and Lothian's Child Protection Programme, which included those elements.

Q. Once again, did this result in an action plan for the school to follow through?

A. Yes, yes, which would be monitored.

Q. The final paragraph here is at 4.1.50, where you tell us that in August 1998 one of the HM Inspector of Schools met the acting headteacher and a member of the Board of Governors; would that be usual, unusual for that sort of direct contact? Not in an inspection context, but another context.

A. I can't say for absolute certainty whether that happened at Raddery, Oakbank and Camphill. There is an inference that it did. All I can say is that here it is accurately stated that the Inspector of Schools met the acting headteacher and a member of the Board of Governors.

I wouldn't be surprised at that, that the Schools Inspectorate want to make sure that the headteacher and Member of the Board of Governors were aware of their concern and being informed of the progress that had been made, so it wasn't just an issue of the, if you like, headteacher following out and saying: yes, I've done that. The Board of Governors were also confirming that those actions had been taken.

Q. You have noted the progress that what actions had been taken, namely, in relation to security, the introduction of a video-controlled entry system, five additional residential staff and, for teachers, a further programme of child protection?

A. That's right, yes, yes.
Q. So these were areas identified by the inspection, which formed part of the action plan?
A. It clearly was. And I think it's obvious that the issues had come as a shock to the Board of Governors.
Q. That was the next point I was going to raise with you. Not only the issues, but also the prevarication by the Headmaster on seeking registration under the 1995 Act?
A. Yes. They had not understood their legal position as a Board of Governors; that they were required as managers of the institution to seek registration and that they were liable as much as the Headmaster, Headteacher.
Q. You then have a short section on Wellington School, Penicuik, 4.1.51, page 140, and again you have the HM Inspector of Schools being assessed by the SWSI in 1999, in connection with a planned inspection of Wellington School?
A. Yes.
Q. And this is a school that's managed by Edinburgh City Council and catered for the needs of 12 to 16-year-old boys with social, emotional and behavioural difficulties. So, again, it's a special school?
A. It's a special school, and I've included this because you can see that the SWSI indicated that it would not be

able to join the inspection team because of other commitments, but would be willing to have an office meeting as a result of the inspection to run through any issues that arose, which it did, the top of the following page.

The level and deployment of staff, assessment of pupils needs, and Wellington's contribution to Edinburgh City Council's Children's Services plan.

Q. Next school you look at is Woodlands School in Newton Stewart, in 1999. And this is in March 1999, the HM Inspector of Schools completed a follow-up inspection of the independently managed residential Woodlands School, so there had been a previous inspection?

A. Yes, there had been a previous inspection. I've included this one because, if you like, because of the caveat role of the Social Work Service Inspectorate, that it wasn't -- they could not really join in the inspection in terms of registration. That was a matter -- they had no locus in that -- that was a matter for Dumfries and Galloway's arm's length Inspectorate. However, if there was an issue about the operation of that arm's length inspection, it would consider investigating the matter.

That's why I've included that. It's not just an HM Inspector of Schools; it's the role of SWSI.

Q. Finally, in this section, you have a review of independent special and grant-aided residential schools, and you mention, in the first paragraph, the schools that are covered and what the outcomes were.

Likewise, at 4.1.56, you indicate that these inspections of Stanmore, Wellington and Woodlands, they form part of the routine inspection programme and were not the results of --

A. No, yes, yes.

Q. And finally in this section, ahead of the 1995 Act, the primary authority central to conduct the inspection of these schools lay with the HM Inspector of Schools?

A. That's right, yes.

MR MACAULAY: My Lady --

LADY SMITH: Is that a good place to break?

MR MACAULAY: I'm virtually finished with this section.

LADY SMITH: I can see that. Very well.

We are going to stop there for today, Professor Levitt. I look forward to welcoming you back tomorrow morning at 10 o'clock. Thank you.

(3.46 pm)

(The Inquiry adjourned until 10.00 am on Wednesday, 31 May 2023)

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