

Scottish Child Abuse Inquiry

Witness Statement of

Marion CRAWFORD

1. My name is Marion Stewart Crawford. When I worked as a Care Inspectorate Inspector, my name was Marion Neil. My date of birth is [REDACTED] 1948. My contact details are known to the Inquiry.

Educational Background

2. I was awarded a Bachelor of Arts in Administration, 2nd class Honours in 1970. I was awarded a Certificate with Merit, Professional Studies and the Practice of Teaching Business Studies and Economics, in 1974 and a Certificate in Guidance, in 1986. Both were from Dundee College of Education. In 1993, I was awarded the Scottish Vocational Educational Council (SCOTVEC) Higher National Units, Child Abuse and Young Children. I was awarded a Post Graduate Diploma in Professional Studies in Education (Guidance and Pastoral Care) Secondary, from St Andrew's College in 1996. In 2006, I was awarded Diploma of Credit, Regulation of Care Award (Scotland), Anglia Ruskin University.

Career History

3. My first teaching post was from 1970 to 1971 as an Economics Teacher at St Joseph's Academy, Kilmarnock. I taught Business Studies and Economics at Arbroath Academy, Arbroath from 1974 to 1987. Thereafter I was an Assistant Principal Teacher, at Linlathen High School, Dundee, from 1987 to 1989.

4. I took a post as Principal Teacher, Guidance and Designated Officer for Child Protection at Baldrigon Academy, Dundee in 1989. I managed the pre-pilot project for the new Community School from 1998 to 1999 and, from 1999 to October 2001, I was the Integration Manager of the new Community School Project, all at Baldrigon Academy.
5. I was seconded to Tayside Regional Council from 1994 to 1995. I worked as Assistant Child Protection Coordinator, Tayside Region, and Family Counsellor at Polepark Family Centre.
6. From October 2001 to January 2002, I was the Education Manager at Redgorton House School, Redgorton. From March to August 2002 I was an Education Social Worker at Perth and Kinross Council. I was a Care Commission Officer, or Inspector, at the Scottish Commission for the Regulation of Care (The Care Inspectorate) for eleven years from August 2002 until I retired on 25th September 2013.

Role of Inspector with the Care Inspectorate

7. Inspectors were responsible for registering care services with the Care Inspectorate, ensuring that the service, its managers, employees and the building where the service takes place, met the necessary national standards for registration. When registering a service, both the Regulation of Care (Scotland) Act 2001 and the appropriate National Care Standards were taken into account.
8. Inspectors visited care services to carry out inspections of all aspects of care, measured against the Regulation of Care (Scotland) Act 2001 and the appropriate National Care Standards for the type of service being inspected. For example, National Care Standards for School Care Accommodation. Inspectors provided verbal feedback to the service manager after the inspection and subsequently issued a report to the service. The report was also published on the Care Inspectorate website, which was accessible to the general public.

9. When inspectors found evidence of areas which could be improved, poor practice, services not meeting the National Care Standard or not adhering to the Regulation of Care (Scotland) Act 2010, they had a range of tools at their disposal. For example, recommending better practice under the heading 'Areas for Improvement', making Recommendations referenced to the appropriate National Care Standard or making a Requirement under the Regulation of Care (Scotland) Act 2010. When a Requirement was made by an inspector, the service must, by law, carry out this Requirement.
10. Members of the public, service users and employees could make complaints to the Care Inspectorate about services or raise concerns that they might have regarding poor practice. Where appropriate, complaints were investigated and scrutinised by inspectors.
11. When I joined the Care Inspectorate these three functions, registration, inspection and complaints, were carried out by inspectors who had a generic role. However by the time I retired, specialised teams of inspectors carried out the three separate functions.

Organisations which I have inspected

12. I have been involved in the inspection of childminders, after school clubs, nurseries which provide day care for children, care homes for children and young people, care homes for older people, day care for adults with additional support needs, school care accommodation services, including boarding schools for pupils with additional support needs, and boarding schools like Merchiston Castle Boarding School.
13. In the first two years I worked for the Care Inspectorate, I inspected predominately early year's services, like childminders and nurseries with some care homes for older people and day care for adults with additional support needs. I then inspected school care accommodation for pupils with additional support needs for approximately nine years. I inspected boarding schools like Merchiston for five to seven years. The National Care Standards for School Care Accommodation did not come into effect until approximately two years after the Scottish Commission for the Regulation of Care was set up.

14. I inspected boarding schools, where required, as a member of a joint inspection team with Her Majesty's Inspectorate of Education (HMIE, now known as Education Scotland). At all times as a Care Inspectorate inspector I was only responsible for inspecting all aspects of care within the school care accommodation services. As an inspector I did not have authority to inspect the education part of the school, that rested with HMIE.

Inspection of boarding schools

Frequency of inspections

15. The frequency of inspections for services was clearly stated in the Regulation of Care (Scotland) Act 2001. For services providing 24 hour care, for example care homes and school care accommodation services, this was one announced inspection and one unannounced inspection per calendar year. I think this changed to two unannounced inspections in 2011 or 2012. In addition the Act stated that additional inspections could be carried out if the Care Inspectorate had serious concerns about the care provided, for example following an allegation of abuse to a service user.
16. In order to allocate resources effectively all inspections were planned in advance, liaising where appropriate with partner agencies like HMIE. However, notifications of difficulties arising may lead to additional inspections. For example, an outbreak of a highly infectious disease notifiable in terms of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), a tragic accident resulting in the death of a service user or a serious complaint or allegation. The Care Inspectorate had a formal written notification system for services to use.
17. On visiting the service the inspectors might find that all the necessary policies and procedures were followed but that the service was not meeting the expected standards. In those circumstances inspectors would carry out further inspections. To use an up to date example, the care home on Islay had additional inspections as their

infection control procedures during the COVID crisis were not up to the expected standard.

18. The difference between the two types of inspection is that the minimum frequency of inspections was clearly stated in the Regulation of Care (Scotland) Act 2001 and those inspections must be carried out. Additional inspections which might be carried out are down to the professional judgement of inspectors and their managers and were based on assessment of risk to service users.

The difference between announced and unannounced inspections

19. Each year the inspection planning team allocated a case load to individual inspectors and they in turn planned their inspections throughout the year, ensuring that all services are inspected as required by law. For announced inspections, the services received a letter from the Care Inspectorate detailing which of the National Care Standards would be reviewed during the inspection and the date of the announced inspection. The letters were sent out approximately four to six weeks prior to the inspection.
20. In the last five or six years that I worked at the Care Commission, significant changes were made to the inspection process. Self-assessment was introduced, based on Quality Themes and Quality Statements. The inspections were carried out against these Quality Themes and Statements, whilst still taking account of the National Care Standards and the Regulation of Care (Scotland) Act 2010.
21. In the last two or three years I worked there, inspection focus areas were introduced and these gave the inspectors an additional focus for the inspection. For example, safer recruitment and child protection. Not all types of services had additional inspection focus areas when they were inspected, as these were decided by Care Inspectorate planning managers. Focus areas were decided as a result of issues raised throughout the year.
22. Following the announced inspection in 24 hour care services, the second, or unannounced, inspection was not notified to the service and generally took place three

months or more after the announced inspection. The main purpose of this inspection was to ensure that the service had acted on any Recommendations and Requirements made at the previous inspection. Generally, if the service was seen to be maintaining standards, the second inspection was a shorter one.

23. The year that I retired, the Care Inspectorate moved to all unannounced inspections. The services were no longer notified in advance of the date of each of the inspections. Services continued to be informed by the Care Inspectorate what National Care Standards and Quality Themes and Statements were being reviewed at the inspection. If appropriate, the service was informed what the inspection focus area was. Services were aware that inspectors routinely checked records to ensure that the Regulation of Care (Scotland) Act 2001 was adhered to.
24. Until 2013, announced inspections were those notified to providers of services by a letter approximately four to six weeks before the inspection. The letter informed providers which areas within the National Care Standards would be reviewed by the Inspector. In the case of school care accommodation services, for example, boarding schools, it was a legal requirement that the school was inspected twice in one calendar year. The second inspection was unannounced. The move to unannounced inspections in 2011 or 2012 was made by the Chief Executive and Senior Managers and was supported by the Board of Directors.
25. Unannounced inspections were part of a move to make the Care Inspectorate more effective. Some of the academic studies on the theory of Regulation argue that unannounced inspections provide a more robust body of evidence during an inspection. I can't remember what reasons we were given for the changes to the inspection schedules, but I suspect it was because of the evidence from regulatory theory, plus I think it was based on the scrutiny and evaluation of previous inspections and to ensure the effectiveness of the Care Inspectorate.
26. Up until 2013, whilst the second inspection of school care accommodation was unannounced, the decision to carry out additional unannounced inspections was made on an individual service basis by an inspection manager and the inspector responsible for the service. For example, if a service was found to be performing poorly at the

second inspection and had not taken any steps to address legal Requirements made at the previous inspection, an additional unannounced inspection would be carried out. The manager and inspector would base this decision on a risk assessment of the service. Risk assessments were carried out by inspectors and stored electronically, as part of the planning of inspections.

Inspection standards for boarding schools

27. There were guidelines, standards and inspection criteria against which an inspection was carried out. They are the Regulation of Care (Scotland) Act 2001, the National Care Standards for School Care Accommodation and the Care Inspectorate's Quality Themes and Quality Statements. These were available on the Scottish Government and Care Inspectorate websites.
28. In addition the Care Inspectorate developed additional guidelines on specialist areas, for example infection control and the storage and administration of medication. Resource information in such areas was also available on the Care Inspectorate's website. The Care Inspectorate had specialists working for them whom inspectors could consult for additional guidance, for example a nutrition adviser, pharmacist adviser and infection control adviser. If deemed necessary, these consultants would also provide information to services.
29. At some point around 2006 to 2008, the Care Inspectorate moved to a system of inspections based on a self-assessment system. Care Services completed an Annual Return and a Self-assessment form annually, prior to the inspection. These documents informed the risk assessments carried out by inspectors prior to inspection. The self-assessment was based on Quality Themes, with each theme containing a number of quality statements. The themes were Quality of Care and Support, Quality of Environment, Quality of Staffing and Quality of Management and Leadership.
30. Working in this way meant that the Care Inspectorate used the self-assessment and associated risk assessment to identify high risk services and those which presented a low risk. There was a scoring system for the answers on the risk assessment, the

score then related to a scale showing low, medium and high risk. The Self-assessment form provided evidence as to how the providers or managers thought they were meeting the Quality Themes and statements. As part of our ongoing training we were informed of the kind of ideal evidence we should be looking for. This enabled us to make an initial assessment of how well the service was adhering to the National Care Standards and the Regulation of Care (Scotland) Act 2010. Sometimes, in some aspects of the form a school might assess themselves as, for example, very good, but the evidence provided in the form meant that they clearly only merited a good.

31. Inspection reports gave a grade against each of the Quality Themes which were inspected. If a service was low risk then not all the themes were inspected. For example, see Inspection Report for the unannounced inspection of Merchiston Castle School dated 29 October 2012, paragraph 2 'How we inspected this service'.
32. The timing of inspections within an inspection year could be influenced by external factors like an outbreak of infectious disease, death of a service user and complaints received about the service. Complainants were generally encouraged to address their complaint directly with the service, in the first instance. In the Inspection Report for the unannounced inspection of Merchiston Castle School dated October 2012, in 'What we did during the inspection', paragraph 3, I stated:-

"We paid particular attention to the documents relating to a concern which was raised by a parent of a former step-up boarder. The concerns raised related to an accident."

33. A step-up boarder is a boarder who does not initially board the whole week. This is usually in order to give the pupil an opportunity to adjust gradually to boarding for example a junior boarder may board on Tuesday and Wednesday nights in the first instance, then move to Monday to Thursday and return home Thursday, Friday, Saturday and Sunday, and finally board for the whole week. Not every boarder does this, as most boarders, the school stated, are happy to board full time from the start.

34. This is an example of how concerns raised can influence the inspection schedule of a service. The Merchiston School's unannounced inspection was scheduled for January to March 2013 but, because of the concerns raised by the parent of a former step-up boarder, the unannounced inspection was brought forward to October 2012. As Merchiston was assessed as a low risk service, the number of Quality Statements we looked at were three for Quality of staffing, and two for the other three themes, as detailed in the report. Details of the Quality Themes and Statements used by the Care Inspectorate were on the organisation's website.

The introduction of specific criteria for boarding schools

35. The Regulation of Care (Scotland) Act 2010 made provision for the inspection of 24 hour care services which, by definition, included school care accommodation services. The National Care Standards for school care accommodation services were not ratified and introduced until 2004, about two years after the Scottish Commission for the Regulation of Care, which became the Care Inspectorate, was established.
36. The establishment of the Care Inspectorate, along with the inspection and regulation of care services, was to raise standards within the care industry. The Care Inspectorate was to ensure that best practice guidance was carried out by all care staff and strengthen policies and procedures. This was to ensure high standards of all aspects of care, including safeguarding, child and vulnerable adult protection. Traditionally boarding house staff were not qualified in the delivery of 24 hour care. There was no formal legal requirement for boarding house staff to have appropriate care based qualifications prior to the Regulation of Care (Scotland) Act and the introduction of the National Care Standards for school care accommodation.
37. By inspecting and regulating school care accommodation services, boarding schools were brought into line with other 24 hour care services. For example, staff who work in boarding houses caring for pupils were required to hold an appropriate care qualification, be registered with the Scottish Social Services Council and adhere to best practice guidance and codes of conduct. As far as I remember the appropriate care qualification is the Certificate of Professional Practice for Boarding Staff (Level 4)

plus the mandatory units from the Scottish Vocational Qualification (SVQ), Social Services (Children and Young People). For managers it is higher, Scottish Credit and Qualifications Framework (SCQF) Level 7 or 9. The qualifications required are those required for Scottish Social Services Council (SSSC) registration and details are on the SSSC website.

38. I can't remember from what date boarding school staff had to become qualified but I think it would have been about two years after the introduction of the National Care Standards for school care accommodation services, around 2012 to 2014. As far as I can remember there were staff in the boarding houses who were working towards qualifications, although some staff already held equivalent qualifications, as detailed by SSSC. In the 2013 Inspection Report of Merchiston School I stated :–

“We saw that staff were registered with professional bodies, for example, General Teaching Council, Scottish Social Services Council. In an example of best practice, a review of staff qualifications confirmed that boarding House staff were either already qualified, or working towards qualifications.”

Training of inspectors

Training on the inspection criteria for care services

39. Initially on joining the Care Inspectorate I received a thorough induction, which included training in how to carry out an inspection and information and learning about both the Regulation of Care (Scotland) Act 2010 and the National Care Standards. Much of this was delivered by a team leader. The induction training included shadowing inspectors on actual inspections of services. Throughout my time with the Care Inspectorate, I received training in different aspects of the inspection process, mainly in the form of training days, and workshops on specific areas. For example, nutrition, child protection and infection control.

40. The Care Inspectorate had a training and development policy. Each inspector was required to attend training days as part of their training and development. Inspectors had regular supervision meetings with their line manager. At the meetings all aspects of their case load, including inspections, were discussed. If required, advice was given regarding any difficulties encountered in the inspection process.
41. Inspectors met with other inspectors, who were regulating the same types of services, for example, school care accommodation services, at the beginning of the inspection year to drill down what issues may arise from the National Care Standards and Quality Statements scheduled for scrutiny that year. This provided a consistent approach from inspectors.
42. As a condition of employment, inspectors had to complete formal training in regulation and inspection. I successfully completed the Diploma of Credit, Regulation of Care Award (Scotland), Anglia Ruskin University, in 2006. This covered the theoretical aspects of inspection, the inspection process, regulating and improving performance, and practice learning in education. Completing this informed my knowledge and understanding of regulation, as well as further developing my skills in the inspection process.

Training on the inspection criteria for boarding schools

43. Inspectors received generic training on the inspection of care services and specific training on inspecting school care accommodation services, when the National Care Standards for school care accommodation services were introduced. As an inspector I received both kinds of training. Inspectors who inspected school care accommodation services met regularly as a group to look at any issues which may have arisen from the inspection process, to ensure that inspections were carried out in a fair and consistent way.
44. Training included two and three day training and workshops specific to school care accommodation. I also took part in joint training with HMIE, for the joint inspections of school care accommodation services. The Care Inspectorate utilised the expertise of

inspectors by ensuring, where possible, that those inspectors who had previously worked in education were members of the school care accommodation teams.

45. The Care Inspectorate worked with providers of services to inform them of best practice guidance for school care accommodation services. One of the ways in which they worked with headmasters was by attending meetings with members of the Scottish Council for Independent Schools. Normally the Care Inspectorate manager with responsibility for school care accommodation attended these meetings. I can remember attending one meeting with the manager. I attended an information sharing day on another occasion, when the Care Inspectorate explained the move to the new grading system to be used with Inspections.

Training on child protection and safeguarding

46. I had a two day workshop on the inspection process for inspecting child protection and safeguarding. I did not receive direct training on child protection and safeguarding matters from the Care Inspectorate. Such training wasn't offered. We did ask for it, but the only training we had was more geared to the inspection aspects of inspecting child protection and safeguarding.
47. You would really need to ask the Care Inspectorate to clarify why such training wasn't offered. Most inspectors of children and young people's services had a background in working with children and young people. For example, in nurseries, residential homes, education services, young people's health services or social work. In these professions they would already have had child protection and safeguarding training.
48. However, in the early days of the Care Inspectorate, when inspectors had a generic role, some inspectors with an adult background were inspecting in children's services. That is where they felt they would have benefitted from extra training. Organising training is a matter of prioritising the organisation's needs along with those of the workforce, whilst taking into account the resources, in terms of both time and money, available to the organisation.

49. Direct training on child protection and safeguarding was not necessarily required to carry out the work of inspector. Inspectors came from a variety of professional backgrounds and, as previously stated, inspectors were deployed according to their background experiences, where possible. The majority of inspectors of children's and young people's services would have had child protection and safeguarding training as part of their own professional development, prior to joining the Care Inspectorate, as I had. If as an inspector you came across information which required clarification, you always had access to other inspectors with that additional knowledge.
50. I was confident that my knowledge and understanding in this area was up to date. This was because in addition to my work as an inspector, I provided child protection training for sports clubs and kept up to date in child protection and safeguarding by attending child protection training provided by Sports Scotland, the National Society for the Prevention of Cruelty to Children (NSPCC) and the Scottish Society for the Prevention of Cruelty to Children (SSPCC). I was the child protection officer for Judo Scotland and worked closely with the British Judo Association, to develop robust safeguarding and child protection policies and procedures for the sport of judo.
51. In my teaching post I was the school's Child Protection Coordinator and had completed an eighteen month secondment as Assistant Child Protection Coordinator for Tayside Region. In that post I delivered child protection training to teachers and ancillary education staff across Tayside and Grampian Regions. I also worked for two days a week with children and their families in a family counselling service which supported children and families, where the children had been victims of abuse.

Process of inspection of a boarding school

52. The specific guidelines and standards relating to inspection of boarding schools are the Regulation of Care (Scotland) Act, 2010, the National Care Standards for School Care Accommodation and the Care Inspectorate's Quality Themes and Statements. These can be found on the Scottish Government's website and on the Care Inspectorate's website.

53. The boarding school was required to complete an Annual Return and a Self-Assessment form every year. I can't remember if this was made available at the start of the inspection year, which was each April, or if the school were informed by letter six to eight weeks before the Inspection was due to be carried out. I think it was the latter. Inspections for school care accommodation used to have one announced inspection and one unannounced. In 2011 to 2012 this changed to two unannounced inspections.
54. As the lead inspector I carried out a desk top risk assessment of the service based on past inspection grades, the information submitted in the Annual Return and Self-Assessment documents, any notifications received from the service or school and any complaints or concerns raised with the Care Inspectorate since the previous inspection. The information in these documents was scored against a formal risk assessment tool.
55. This explains why the inspection of Merchiston in October 2012 was deemed to be a low intensity inspection. There were no serious issues arising from the Annual Return and Self-Assessment documents. There was a record of an incident where a step-up boarder was involved in a minor accident. His father hadn't raised a formal complaint but only raised concerns about how it was handled by the school. During the inspection I looked at this and the records associated with it, as well as speaking to pupils involved, and my findings are in the report. If an incident or accident is not serious inspectors can suggest to the complainant that the issue is looked at as part of the Inspection process and I think that was the case in the October 2012 inspection.
56. The 2013 inspection of Merchiston was a medium intensity inspection. This was because the school had notified us about the historical child protection issues. This information significantly raised the score on the risk assessment and so the inspection was deemed to require a medium intensity inspection.
57. In unannounced inspections, the inspector visited the school and asked to speak to the manager, at a boarding school this was the Headmaster. The inspector briefly outlined the inspection process to the Headmaster. In a service the size of Merchiston,

the inspectors may need to carry out the inspection over more than one day, as was the case with the 2012 inspection of Merchiston.

58. At every inspection of a boarding school, inspectors scrutinised a range of documents relating to the areas under scrutiny, interviewed boarding staff and, if appropriate, spoke with teaching staff too. Teaching staffs' records would only be reviewed and teaching staff would only be spoken to where they had a boarding house role or where their role impacted directly on an area being inspected.
59. At Merchiston, if my memory is correct, the school's Child Protection Coordinator was a member of the teaching staff and the Assistant Child Protection Coordinator was a member of the boarding staff. It is quite common in boarding schools for staff to have dual roles and to be a member of the boarding staff and a teacher as well. Some schools have boarding staff who are not teachers and vice versa.
60. Inspectors spoke to pupils at the school as well, usually in small groups. Normally the school selected the pupils, unless inspectors wished to speak with specific pupils. For example, I requested to speak to the pupils who had been involved in the incident or accident involving the step-up boarder, in the 2012 inspection at Merchiston. Inspectors would also ask the Head teacher to let pupils know a time when the inspectors would be available to speak to them, if they wished, on a one to one basis.
61. Inspectors spoke to parents and carers as well, if appropriate or necessary to do so. Speaking to parents and carers was not a standard part of every inspection because the service users of the service were the pupils and it was part of every inspection to speak with a sample of pupils.
62. During the inspection, inspectors sampled a range of records, which included those pertaining to the Regulation of Care (Scotland) Act 2010. For example, certificate of registration and staffing schedule, public liability insurance, records of medication administered and accidents and incidents.
63. At the end of the visit to the boarding school, the inspector provided the Head teacher with verbal feedback on the inspection findings and gave the provisional grades

awarded, with the caveat that these may change in the final report. The inspector then wrote the Inspection Report, detailing the final grades awarded. If deemed necessary, consultation with the inspector's line manager over the grades awarded may take place. Once the report was written it was sent to the inspector's line manager for approval. Following approval, the report was issued to the service and published online, on the Care Inspectorate's website.

64. If the inspector had made Requirements or Recommendations in the Report, the service was required to respond to the Report by providing the Care Inspectorate with information as to what measures they had carried out to meet the Requirements or Recommendations. If a number of Requirements were made, inspectors would carry out a follow-up unannounced inspection of the school, within a short timescale.

Carrying out the inspection of a boarding school

Speaking to the Headmaster and school staff

65. Inspectors spoke to the Headmaster and boarding house staff, individually or in groups. They spoke to pupils, other senior managers, catering manager and staff and, where appropriate, administration staff. For example, if administration staff had responsibility for the school's recruitment process or managed and appropriately stored pupil's records. The inspectors spoke to the school's Child Protection Coordinator. Inspectors also spoke to any on site medical staff. They may speak to some teaching staff where those staff have boarding responsibilities, for example, supervising prep time, or coordinating after school activities. Staff spoken too will vary according to the Quality Statements looked at during the inspection process and if there is any inspection focus area.

School control over who is spoken to by inspectors

66. With respect to boarding and school staff interviewed, the school does not have control over who is spoken to. The school cannot refuse to let an inspector speak to individual staff. The right to interview staff, as far as I remember, was laid down in the regulation

of care legislation. The school only nominates who can be spoken to if, for example, the inspector requests to speak to two senior boarding masters and one from the junior boarding houses.

67. The school usually nominated which pupils were spoken to. The inspector might ask to speak to four prefects, six junior boarders and six boarders from the middle school. The school would provide pupils meeting that criteria. In the October 2012 inspection of Merchiston, I spoke with 28 pupils which was 3.5 % of the boarding population. It was left to the professional judgement of the inspector, taking into account the inspection risk assessment, how many pupils were interviewed.
68. In the October 2012 inspection I specifically asked to speak to the boys who were involved in the incident which resulted in the accident to the step-up boarder. I was able to cross reference their names with the accident report, so I knew I was speaking to the right boys. Schools were cooperative in providing pupils to speak with and provided access to specific pupils, for example, pupils in their pupil school council. Under regulatory legislation, inspectors had the right to speak to individual pupils.

Speaking to parents

69. It is more difficult to speak to parents as part of the inspection process, unless your visit is timed to coincide with a time when parents and carers may be at the school. Inspectors could interview parents by telephone if they wished to, send out questionnaires or take account of other ways in which the school sought parents' views. In the October 2012 inspection, I scrutinised the questionnaires that the school had given to parents and carers. As far as I can remember those questionnaires were prepared by an outside consultant employed by the school. I also scrutinised questionnaires from a survey by the Scottish Boarding Schools which was carried out by an independent consultant.
70. Any questionnaires sent out by the Care Inspectorate were confidential. They would be sent out and returned to the Care Inspectorate. They would be seen by Care Inspectorate administration staff and by the inspector for the service. The

questionnaires would ask general questions relating to the service, taking account of the National Care Standards for school care accommodation services.

71. Parents Associations would be contacted if, in the professional opinion of the inspector, their views should be sought. Technically, the pupils are the service user in the service, not the parents. The regulations and standards state that the views of the service users should always be taken into account. Unless there was a specific need to contact parents, for example if there were a number of complaints from parents, then parent's views would not always be sought.

Contact with pupils and parents prior to the inspection

72. Pupils and parents would not generally contact inspectors prior to an inspection. They wouldn't know when an inspection was due to take place. Inspectors would not routinely contact pupils, parents and carers prior to the inspection process.
73. Pupils, parents and carers can raise concerns and complaints with the Care Inspectorate. Depending on the detail of the issue these concerns and complaints would be investigated by an inspector. This process would involve a face to face or telephone interview with the complainant, who could be parent, carer or pupil, and a visit to the service or an unannounced inspection visit. The complaints procedures are robust. They include informing the complainant by letter of the action taken and the results of any complaints investigation.

Access to documents in the boarding school

74. Inspectors scrutinised documents in the school which would evidence that the school was adhering to the Regulation of Care (Scotland) Act 2010. The documents were the certificate of registration and staffing schedule, public liability insurance, records of purchase, storage, administration and disposal of medication, accidents and incidents and written risk assessments.
75. A sample of documents and records which evidenced what the school was achieving under the specific Quality Themes and Quality Statements were scrutinised. For

example, samples of pupil's care plans, known as 'Getting it right for every child' (GIRFEC) and education plans (pupil profiles).

76. Other examples were the scrutiny of meetings including meetings with the Board of Governors, senior leadership meetings, housemaster's meetings and Prefect's meetings. Other examples of documents scrutinised were questionnaires and surveys carried out by the school, information to parents and carers, information from the school's website, the school's self-evaluation and quality assurance systems.

Child protection and safeguarding

77. The inspector would expect the school to have robust policies and procedures in child protection and safeguarding, along with suitably qualified staff in roles such as child protection coordination for the school. In the 2012 inspection of Merchiston, I spoke with a member of the Board of Governors about the school's Child Protection Review. I did not see Governor involvement expand over my time as inspector. It was always difficult to access Governors as most had full time jobs and were not available when inspections took place.
78. Governor involvement helped in certain circumstances, especially if there were problems which required their attention. For example, I inspected the New School, Butterstone, near Pitlochry. There were significant problems with the head teacher and the opportunity to alert one of the Governors to the problems in a face to face meeting was helpful. The head teacher was not good at managing staff, especially care staff, and didn't have a robust understanding of the pupils' difficulties. Many of the pupils were on the spectrum for autism. The head teacher left the school and the school closed about two years ago.
79. The inspector would look for evidence that all staff or, at the very least, those who had regular contact with pupils, had received child protection training and that this was part of an ongoing training and development plan for the staff.
80. The inspector would interview a sample of staff and pupils to ensure that the school's child protection and safeguarding policies and procedures were known to them. In

particular they would look for evidence from pupils and from staff that they knew how to report concerns and who those concerns should be reported to. They would interview the Child Protection Coordinator and Assistant Child Protection Coordinator to ensure that they knew how to proceed should concerns or an allegation be raised with them. The inspector would scrutinise any records of child protection incidents, paying particular attention to how these were dealt with and what the outcome was.

Length of an inspection

81. For a medium intensity inspection, an inspection could take a day or two days, depending on the size of the service and how many inspectors were involved. In 2012 I was the sole inspector for the service, despite its size. This was due to staff illness. The inspection took approximately 25 hours because, although it was a low intensity inspection, I carried out additional scrutiny of records and additional interviews with pupils and staff, whilst reviewing the incident or accident to the step-up boarder.
82. In contrast, the 2013 medium intensity inspection took approximately twelve hours, with two inspectors. This was a more normal timescale. There was not a time restriction on the length of the inspection but inspectors were expected to utilise their inspection time appropriately. If the inspectors became aware of serious concerns about the service then the inspection process would take longer than normal, in order to scrutinise all the evidence.

Recording the inspection

83. Inspectors took down notes throughout the inspection. I recorded these either as a handwritten record on a notes template or on the notes template using my laptop. Latterly the template for inspection reports was available online on iPads and I recorded my notes directly into the report, which made editing and writing the report a quicker process.

Inspector's powers to ensure cooperation from the school

84. The powers of inspectors were clearly laid out in the Regulation of Care (Scotland) Act 2010 and included presenting a case to the Sheriff. During my time as an inspector, I never carried out an inspection on a school care accommodation service where the school was not cooperative, although some were more cooperative than others. I found initially when inspecting school care accommodation services that some head teachers were, in discussions about the inspections, quite dismissive of the role of the Care Inspectorate. As inspectors we worked hard to establish positive relationships with providers and head teachers through continually reiterating what our role was and in what ways the inspection process would benefit the organisation. Over time the majority of head teachers realised that the Care Inspectorate was carrying out a legal, regulatory role, and that through the sharing of good practice, based on sound evidence, the inspections in fact could benefit the organisation.
85. The inspection reports were a summary of our findings against the areas we were inspecting, quality statements, focus areas, National Care Standards, the Regulation of Care (Scotland) Act 2010. As such they would not imply that a head teacher was less than cooperative. However this might be evident from what was stated in the report. For example, if at a previous inspection recommendations for improvement were made but ignored by the service, in the subsequent inspection this would be clearly stated. Depending on the actual recommendation, it might be escalated to a requirement under the Regulation of Care (Scotland) Act 2010.
86. In saying that some schools were more cooperative than others, I am not thinking of any school or schools in particular. In discussions with colleagues who also inspected school care accommodation services, it was clear that when we first inspected these services, many of them were unsure of our role as inspectors and queried why they had been included in the Regulation of Care (Scotland) Act 2010. This meant that, as inspectors, we had to work very hard to establish our role, to prove our competence to head teachers and to show that the inspection processes were robust, fair and proportionate. I wouldn't say that the boarding schools as a whole were less cooperative or guarded, more that certain individuals within school organisations could

be quite hostile, uncooperative and guarded, depending on what I was talking to them about.

87. As inspectors we were encouraged to work with providers and managers. Usually, explaining that something was definitely within the scope of the Act was sufficient to guarantee cooperation. The more inspections we carried out in this sector, the more headmasters and boarding staff realised that adhering to the National Care Standards provided them with a bed rock of good practice.

Process following an inspection

88. The lead inspector would collate the notes from both inspectors. Through discussion with each other, and based on the evidence found, both inspectors would agree provisional grades to give the service at the verbal feedback. The lead inspector would write the report using all the collated notes and evidence and would, as necessary, consult the other inspector. The draft inspection report would be shared with the other inspector who might wish changes, which were discussed and agreed. The final version of the report was then submitted to the lead inspector's line manager for approval, before the report was sent to the school and published on the Care Inspectorate website.
89. The inspectors gave the provider, who is the Headmaster, verbal feedback with provisional grades at the end of the inspection. The inspectors usually give the service a rough timescale of when the report would be sent out and published. The report is written and then published on the Care Inspectorate's website.
90. The only opportunity the school has to influence the report and its grades is during the verbal feedback. Headmasters frequently try to influence the reports. In the discussions at the end of the inspection process when we provided the head teacher with a summary of our findings and provisional grades, sometimes the head teacher or member of the senior management team who might also be present, would disagree with our findings. In those circumstances, through discussion, they might try to influence the provisional grades.

91. However, if you have enough robust evidence it is easy to stick to your initial assessment. This is particularly the case where aspects of the Regulation of Care (Scotland) Act 2010 have been breached. For example, some schools initially did not realise that they were required by law to inform the Care Inspectorate of an outbreak of infectious disease.

Merchiston Castle School, Edinburgh

92. I can't remember when I was first involved in inspecting Merchiston Boarding School. I think I inspected it for about four years and one of the inspections may have been a joint one with HMIE. I think I carried out inspections in 2010, 2011, 2012 and 2013. I am fairly certain that I was only lead inspector in 2012 and 2013.

The inspection of October 2012

93. Merchiston was on my case load for inspection in 2012. As lead inspector I would have carried out the desk top risk assessment prior to visiting the service. The inspection was not due until early the following year, in January to March 2013. The decision was taken, in consultation with my manager, that the inspection would be brought forward. This was because a parent, who worked abroad and was the father of a step-up boarder, raised concerns about the school's handling of an incident or accident involving his son. The parent withdrew his son from Merchiston because of this but wished the Care Inspectorate to be aware of his concerns. The parent did not make a formal complaint against the school to the Care Inspectorate but agreed to us addressing his concerns during an inspection.
94. There was a considerable time lag between the parent first raising his concerns, the inspection visit and the published report, because it was very difficult to communicate with the parent. The parent was frequently abroad. I was due to carry out the inspection with a colleague but, due to illness, and in order to avoid further delays, my manager instructed me to carry it out on my own. In other types of smaller services, it is the

norm that inspectors carry out inspections on their own. I was provided with information about the accident or incident prior to the inspection visit and had access to all the other tools normally used to prepare for an inspection visit.

95. The school was surprised at the timing of the visit but, as always, was welcoming. The Care Inspectorate had established a good working relationship with the school, in line with best practice regulatory guidance. The school was more than happy to cooperate when the reason for the timing of the inspection was explained to them. They made all the necessary documents and records available for me and arranged for me to speak with pupils and staff, as detailed in the 2012 report.
96. During the inspection visit there were two members of staff, one boarding staff and one teacher with responsibility for extra-curricular activities, who found the questioning and review of documents challenging. They were both defensive when answering my questions. I can't remember their names. One was a Physical Education teacher with responsibility for outdoor education and trips to activity centres. The other was the boarding house Master of the Junior School boarding house, which I think was called Pringle. He was [REDACTED]
97. The boarding house Master queried my line of questioning, when I talked to him about his long association with the former teacher who was the subject of the school's historical abuse allegations. He stated quite forcefully that this was outwith my remit as an inspector. I had to explain to him what the role of the inspector was and he did answer my questions.
98. The other member of staff was most unhappy that I had access to his staff file. He was adamant that this was outwith my remit as an inspector. However, after a fairly difficult interview he asked to speak with me the next day and apologised for his attitude. He said he now understood that I was only doing my job. This was fully discussed with the Headmaster, as part of the inspection process.

The inspection process in October 2012

99. The process I followed is clearly stated in the 2012 Inspection Report at section 2, pages 7, 8 and 9. I spoke with the Headmaster, the Senior Deputy Head, members of the boarding staff teams, including housemasters and a house parent, all of the staff who dealt with the incident or accident, a sample of pupils, including prefects, the Coordinator and Deputy Coordinator for Child Protection, the school's medical staff, and the Headmaster's Personal Assistant.
100. The school provided us with all the documents and records we asked to scrutinise. The range of documents I scrutinised, as part of this inspection, are detailed at section 8(k) of the 2012 Report. I scrutinised additional records in relation to accidents and incidents. Those records were the whole scale review of boarding and supervision arrangements in the boarding house following the accident or incident which triggered the timing of the inspection. These are detailed at pages 22 and 23 of the 2012 Report.
101. I scrutinised the annual audit of rugby injuries and written permission from parents and carers for the administration of medication. The school provided their risk assessments for the environment, both outside and inside. The risk assessments covered sporting activities, co-curricular activities, outside play for younger pupils and dogs. These are referenced at page 29 of the 2012 Report. I scrutinised complaints and complaints' audits and a sample of recent recruitment records for both boarding staff and ancillary staff.
102. I spoke with 28 pupils in total. I did not speak to parents but I took account of parents and carers comments in a questionnaire carried out by the school and comments in a survey carried out by the Scottish Boarding Schools.

Outcome of the inspection of October 2012

103. The inspection resulted in the school being awarded Grade 6, Excellent, for the Quality of Care and Support, the Quality of Environment, Quality of Staffing and the Quality of Management and Leadership. Some areas for improvement were

suggested to the school. Two of those were in place by the time of our final visit, which was to provide feedback.

104. Prior to finalising the Inspection Report, I discussed my findings with my line manager. This was to ensure that during the inspection visit I had covered all aspects relating to the accident or incident to the step-up boarder. The Inspection Report was, in accordance with Care Inspectorate process, sent to my line manager for approval before it was sent to the school and prior to publication on the Care Inspectorate's website.
105. Services, which in this case was Merchiston, are not provided with a draft report for comment. The only opportunity the service has to influence the outcome of the inspection is at the verbal feedback given at the end of the inspection visit.

Contact with Merchiston prior to the inspection in September 2013

106. I had contact with Merchiston between October 2012 and September 2013 when the school informed us of the historical abuse case which, following allegations of historical abuse, was being investigated. This is referred to at page 7 of the 2013 Inspection Report. Contact between inspections was not unusual, as Headmasters might wish to contact us for advice or might make contact to notify us of, for example, a serious accident or incidents.
107. The reason we had contact with Merchiston is that it is normal for the school to contact us for advice or guidance. To comply with the Regulation of Care (Scotland) Act 2010, the contact is by telephone and in a written notification form. The Care Inspectorate has a formal notification system, as previously explained. I think the contact was initially a phone call, prior to the Head teacher notifying us formally.
108. Merchiston's Headmaster and I discussed what the allegation was, who had made it, who it was against and whether or not that person had a role at the school currently. The allegation was made by a former pupil against a retired member of staff. We also discussed what action, if any, the school was now taking.

109. I believe that the member of staff was past retirement age and still lived on site at the school, although not in a boarding house. He still had a peripheral role at the school, for example, driving the mini-bus. The Head teacher suspended him from all duties when the allegation came to light and, following that, the alleged perpetrator died by committing suicide. This happened, fairly soon after he was suspended and before the outcome of the investigation was known. The Headmaster kept the Care Inspectorate informed of all of this, initially in phone calls, but he also sent in notifications too. I cannot guarantee the veracity of my answer as I honestly can't remember all the details.

The inspection of September 2013

110. The inspection in 2013 was a routine inspection in line with the Care Inspectorate's annual schedule of inspections. I was allocated to lead on this inspection by the Care Inspectorate's inspection planning team, as this service was part of my caseload. By 2013 the Care Inspectorate was moving towards specialised teams and I had a number of school care accommodation services on my caseload. I was accompanied on this inspection by Iain Lamb, a colleague who was also experienced in inspecting school care accommodation services.
111. It was usual for inspectors to inspect the same services. However, caseloads were reviewed annually by the inspection planning team. There were generally some changes, to ensure that inspectors did not succumb to regulatory capture. Regulatory capture is where the inspector assumes that a service is performing well because of information provided by the manager, and does not thoroughly evidence the veracity of the information provided. There is a fine line between inspecting a service for a number of years, in order to work with managers and providers of services to ensure their co-operation in improving their services, and becoming complacent and just assuming because they had good grades last year, that the service will continue to have good grades.
112. As stated at page 7 of the 2013 Inspection Report, one of the focuses of the inspection was a review of the school's current safeguarding policies and procedures. This was

due to child protection issues, those being the historical abuse enquiry which the school had dealt with the previous term. The school, its staff and pupils were, as always, welcoming and cooperative throughout the inspection.

The inspection process in September 2013

113. The process I followed is detailed on pages 7 and 8 of the 2013 Inspection Report. I carried out a desk top risk assessment prior to the visit. The assessment included taking into account the telephone calls and written notification from the school about the historical abuse enquiry and an examination of the school's Annual Return and Self-Assessment form. Based on this risk assessment, the school required a medium intensity inspection.
114. My colleague and I talked to the Headmaster and members of the school's staff teams. We discussed progress made since the previous inspection visit. Documents we reviewed were detailed in page 8 of the Inspection Report. Staff we spoke with are detailed on page 8 of the Report.
115. My colleague and I spoke with two groups of six pupils and attended a prefect's meeting. We scrutinised the school's consultation with pupils. We looked at a sample of pupil's care plans (GIRFEC) and education plans (pupil profiles). As with all lengthy inspections we sat beside pupils and staff during at least one mealtime, which gave us an additional opportunity to chat to pupils and staff informally. The staff were open and cooperative, other than the two members of staff referred to in paragraph 95 of my statement. The pupils were very cooperative and were happy to take part in discussions with the inspectors.
116. We did not speak to parents and carers. We looked at surveys and questionnaires carried out by the service.

Outcome of the inspection of September 2013

117. The school was awarded Grade 6, Excellent, for the Quality Themes and Statements we inspected against, as detailed in the Report dated 2013. In line with the Care

Inspectorate's processes, the school only had an opportunity to influence the report during the feedback discussion with the two inspectors at the end of the inspection visit.

118. Again, in line with the Care Inspectorate's processes, the Inspection Report was reviewed and approved by my line manager. I think I also discussed the Report with her in detail, prior to her approving it, given the allegations of historical abuse. I certainly remember for both the 2012 and 2013 inspections that I had a number of consultations with my line managers about the school and the inspection process required to address firstly, the concerns raised by the parent referred to in the 2012 Report and secondly, the historical abuse referred to in the 2013 Report.

Joint Inspection with Her Majesty's Inspectorate of Education, October 2014

119. A joint inspection was an inspection carried out by Care Inspectorate inspectors along with inspectors from another agency. In October 2014 the other agency was HMIE. During this type of inspection the two teams of inspectors worked together to scrutinise both the care provided as well as the education. A joint report was produced and any Requirements and Recommendations made by the Care Inspectorate were noted in this report, as were any areas for improvement. The process was very similar, however HMIE do not have the power of the law behind them and so regulatory Requirements were made, if required, by the Care Inspectorate.

Recommendations, Requirements and failings noted in the 2014 inspection

120. I am told that it was noted in the 2014 inspection, for example, that the Human Resource systems had not always been used effectively in recruitment of teaching staff and disciplinary matters, that the school relied too heavily on informal approaches and needed to consider where more formal systems for improvement were needed. I am asked to explain why Recommendations and Requirements in response to these matters were not made in the Inspection Reports of 2012 or 2013, or earlier. I do not have access to the 2014 Joint Inspection Report, as I was not involved in this inspection. I retired from the Care Inspectorate on 25 September 2013.

121. My findings from the 2012 Inspection are detailed under Quality Theme 3, Quality of Staffing, in the Inspection Report dated October 2012, at pages 33, 34 and 35. I reviewed a sample of recent recruitment records. The review was to verify if the school was now adhering to the Recommendation made at the previous inspection visit in February 2012. The Recommendation was as follows:-

“It is recommended as good practice that the school develops a recruitment policy and reviews its current recruitment procedure to include a recording system for all stages of the recruitment process, including confirmation of physical and mental fitness and a written record of telephone references for Domestic staff, if they are unable to obtain a written one. With reference to National Care Standards school care accommodation services, Standard 7(7) – management and staffing”.

122. Safer recruitment was an inspection focus area for most services and the Care Inspectorate had an inspection focus area of Safer Recruitment in a previous inspection year, possibly 2011 to 2012. I can't remember what the other inspection focus areas might have been. The way we inspected this inspection focus area was very specific and concentrated on aspects of safer recruitment. For example, medical fitness to work, references, Protection of Vulnerable Groups checks, systems to record these, retrospective checks, identity checks and eligibility to work in the UK.
123. The way the Care Inspectorate inspections worked was that, if a Requirement or Recommendation was made in an inspection report, then that was followed up at the next inspection visit. This meant that I followed up on the Recommendation from the previous inspection visit but did not carry out a full safer recruitment inspection.
124. I only reviewed recruitment files relating to boarding staff and domestic or ancillary staff, not teaching staff. This is because reviewing recruitment files for teaching staff was outwith my remit. Teaching staff are subject to review by Her Majesty's Inspectorate for Education (HMIE), now Education Scotland. In the files I reviewed, there was no evidence of informal approaches to safer recruitment nor of

discrepancies in staff disciplinary matters. I can't remember how many files I reviewed but I did review staff files and pupil records.

125. Unless serious disciplinary matters were raised directly with us as a concern, for example through a complaint, or were highlighted in either the Annual Return or Self-Assessment form or in a Notification to the Care Inspectorate by the school, it is unlikely that we would be aware of them, unless disciplinary matters were included in the particular Quality Theme and Quality Statement we were examining in that inspection. For instance, we would sample staff records pertaining to disciplinary issues. We had the legal authority to ask for specific staff records, if we were aware of an issue with a particular member of staff.
126. The sample of sample records pertaining to disciplinary issues would include teaching staff. In the 2013 Inspection of Merchiston, the staff records would only have included teaching staff if they had a dual teaching and boarding role. As I have previously stated I did look at the staff file for the Physical Education teacher with responsibility for outdoor education and residential. I may have checked teachers' records of child protection training. For example, I think both the school's Child Protection Coordinator and the Assistant Child Protection Coordinator were teachers as well as having boarding responsibilities. I would have reviewed a sample of non-teaching staff files of boarding house staff who were not teachers.
127. The Care Inspectorate had a notification system. Care services had to, by law, notify us of, for example, serious accidents or incidents. If the school had abuse allegations against a member of staff or sacked them because of major misconduct they were required to notify us. If they did not do this, then we would not know about major incidents. The Headmaster of Merchiston School was very good sending in notifications and in telephoning first to discuss his concerns. If a school did not notify the Care Inspectorate of an incident or allegation, the incident or allegation might come to the attention of inspectors by a report from a parent or carer to the Care Inspectorate. A pupil might contact the Care Inspectorate and information about how to contact us was displayed in the boarding houses. Inspectors might have picked up the incident or allegation when reviewing staff or pupil files.

Inspection of other boarding schools

128. I inspected Queen Victoria School on two occasions but I do not remember the dates. I was a second inspector in one of the inspections and may have been a lead inspector in another inspection. I do not remember very much about the inspections at all and I do not remember there being any major issues with either inspections.
129. Morrison's Academy did not have boarding pupils during the time I worked for the Care Inspectorate, so we only inspected the nursery school. The nursery school was operating at a very good standard, with enthusiastic, knowledgeable staff.

Common themes in boarding schools

130. Common themes were that initially boarding house staff were very apprehensive about our inspections and some staff were reluctant to gain qualifications. Over the years we inspected school care accommodation services, this fear and reluctance dissipated and for the most part schools looked to us as a resource to enhance best practice.
131. There was, in some schools, the perception that care staff were less valued members of staff. Therefore some teaching staff were dismissive of the boarding staff's role in providing boarding care. This was apparent when we interviewed teaching staff who were also involved in boarding responsibilities and when we chatted to them over meals.
132. I found that some teaching staff often, even as late on as 2012, had little or no understanding of the Care Inspectorate or its role in regulating boarding schools. One of the members of staff, to whom I referred earlier at the October 2012 inspection of Merchiston and who was defensive, objected to me reviewing his staff file. He found it difficult to accept that I had the legal authority to scrutinise staff files, if they pertained to the inspection.

Issues arising from inspection of boarding schools outwith the case study


133. On the positive side, boarding school staff who embarked on gaining qualifications, were very positive about the difference it made to the way they worked and how they relished putting into practice additional best practice guidance from their learning.
134. Between 2012 and 2013 the Care Inspectorate manager with responsibility for school care accommodation services asked me to attend a meeting with the Scottish Council of Independent Schools. The purpose of the meeting was to discuss changes the Care Inspectorate was making to its inspection processes and to reinforce the necessity for boarding schools to make Notifications to the Care Inspectorate, as detailed in the Regulation of Care Act (Scotland) 2010.
135. At the meeting I had to take the Headmaster of Cargilfield Preparatory School, Edinburgh aside and explain to him, in no uncertain terms, that he must comply with the law. I do not recall his name but he is no longer the Headmaster of the school. The Headmaster had remained very outspoken throughout the meeting about the need to make any changes to his practice, saying "the school has always done it this way" and "it's never been an issue so why should we change now." I found his attitude very difficult and to be fair to the rest of the Headmasters present, he did not get any support from them.

Other comments about the current system of inspection

136. Initially I found that one or two boarding schools I inspected, were naive about child protection. Those were Kilgraston School, St Mary's Music School and St Leonard's School. They hadn't had child protection issues in the past and so just assumed that "nothing like that would happen here." This meant that their understanding of policies and procedures was limited, as were their actual policies and procedures. By putting appropriate training in place, developing robust policies and procedures and raising

the profile of safeguarding in the school as a whole, over time, there was a marked improvement in safeguarding.

137. During my time working as an inspector, whilst we had appropriate training on the processes of inspecting safeguarding, in general discussions, some inspectors who did not have a child care background per se, complained that they did not get appropriate child protection training. This meant, they said, that where they were involved in inspecting children and young people's services they thought that their knowledge base in safeguarding was inadequate. As I have been retired for seven years, I hope that these concerns have now been addressed by the Care Inspectorate.
138. Overall during the eleven years I worked as an inspector, I was heartened to see the changes in services over the years. In my view this was down to two main issues. Firstly, the regulatory process and the way in which this improved overall care, and secondly, the requirement to have qualified, knowledgeable staff. First rate managers also make a huge difference as do providers who invest in staff training.
139. I know it isn't perfect throughout care services. However, by the time I retired, my view was that the majority of services, including school care accommodation, were moving in the right direction and ensuring high quality safeguarding for the children and young people in their care.
140. I would like to reiterate that my statement is a reflection of my recollections from seven to ten years ago and that I am hazy on dates. The information I have given reflect my recollections, not necessarily current practice in the Care Inspectorate.
141. I have no objection to my witness statement being published as part of the evidence to the Inquiry. I believe the facts stated in this witness statement are true.

Signed..........

25 November 2020

Dated.....