Thursday, 15 May 2025

(10.00 am)

LADY SMITH: Good morning, and welcome back to Phase 9, the phase in which we're looking at the provision of healthcare institutions, additional support needs institutions and disabilities provision for children in care.

Today will be the last day of this section and we have one witness to give evidence, I think, is that right?

MS INNES: That's correct, my Lady.

This next witness is Charlotte Wilson, who is currently on a seconded post as Chief Inspector of Children and Young People with the Care Inspectorate.

LADY SMITH: Thank you.

Charlotte Wilson (affirmed)

LADY SMITH: Thank you for coming along so that the Care Inspectorate can help us again, and I know we have put quite a burden on them in the course of this Inquiry so far.

Would you like me to use your first name or your second name, I'm happy to do either, Ms Wilson or Charlotte, which would work for you?

A. Charlotte's fine, thanks.

LADY SMITH: Thank you Charlotte.

I think you're well aware of what you're here for today and we have the background of all the helpful written responses that the Inspectorate has already provided, but there are particular matters, for the purposes of this phase, that we'd like to explore with you.

If you've got any questions at any time, do speak up. If you want a break, that's fine. If you're still giving evidence at 11.30 am, I take a break about then anyway, so you can plan for that.

If you have no other questions at the moment -- you'll know that the paperwork's in the red folder there in front of you and we use the screen as well to bring documents up. If you have no other questions at the moment, I'll hand over to Ms Innes, is that right?

MS INNES: Yes, thank you.

LADY SMITH: Thank you.

MS INNES: Thank you, my Lady.

Questions by Ms Innes

MS INNES: Charlotte, we understand that you are currently in a seconded post as Chief Inspector for Children and Young People with the Care Inspectorate?

A. That's correct.

Q. I think your usual role is as a Service Manager for Children and Young People with the Care Inspectorate?

A. That's correct.
Q. And you've been in that role since January 2022 and in your seconded role since September of last year?
A. Yeah, that's correct.
Q. You have provided us with a copy of your CV and I just want to have a look at some aspects of that.

You tell us that you have various professional qualifications, including a degree of Bachelor of Arts in Education Studies, which you graduated from in July 2005. You have some postgraduate qualifications as well, I think an MSc?
A. Yes, in residential childcare.
Q. Are you currently undertaking a PhD?
A. Yeah, I'm just in the process of finishing a PhD in social work.
Q. You tell us that that is focusing on exploring the impact of secure care on the identity constructions of autistic young people?
A. That's correct.
Q. You also tell us about your experience in the workplace and I think you worked for a number of years for Barnardo's as a residential project worker?
A. That's right.
Q. In 2011, you undertook a specific support service role for Barnardo's supporting two families with children

with learning disabilities?

A. Yeah, that was a pilot project that I was seconded into.

Q. Then you worked at Donaldson's School as a senior residential care worker from November 2011 until September 2014?

A. That's right.

Q. Just to pause there; Donaldson's School is obviously one of the institutions focused on in this case study, but just to be clear that you're here today to speak about your role in the Care Inspectorate as opposed to your personal experience --

A. Yes.

Q. -- at Donaldson's.

Then after you had worked at Donaldson's, you went to work with Barnardo's again as a team manager, this time, in West Lothian?

A. Yes, that's correct.

Q. And then you worked as a care services manager in East Park. Am I right in understanding that East Park is a specialist provision for children with additional support needs, including autism?

A. Yes, all of the services that I worked in were for children with some sort of additional support needs or disabilities.

Q. Then, after you left East Park, you joined the Care

Inspectorate in January 2018?

A. Er -- yes. Yes, that's correct.

Q. You also tell us that you have done a number of things in relation to disability. So, for example, you have made a podcast on disability?

A. Yeah, for a masters course.

Q. Since then you have delivered annual input on disabilities to the MSc on advanced residential childcare?

A. That's right.

Q. And you've had several papers published as well?

A. That's correct.

Q. Okay. Now, moving to the Care Inspectorate's report for this phase of the Inquiry, that's at CIS-000010042. It will come up on the screen. If we move to page 4 and paragraph 1.4, we see there that it tells us:

'This report focuses on residential childcare for children with long-term healthcare needs, additional support needs and disabilities and information specific to the Care Inspectorate's role, responsibilities and practice in relation to certain establishments providing such care.'

So this is the focus of this report. We know that the Care Inspectorate have previously provided reports to the Inquiry and given evidence so this report should

be read alongside that previous evidence and material?
A. That's correct.
Q. If we can move to page 5, please, in section 2, this is a section dealing with the Care Inspectorate's structure, roles and responsibilities, and the Care Inspectorate has previously given evidence as to its structure. Since the Inspectorate last gave evidence, at paragraph 2.1.1, we see that it says:
'The post of Chief Inspector for Children and Young People Services was increased in September 2024, on a temporary basis for one year, to a full-time role.'
A. That's correct.
Q. So that's the role that you're undertaking?
A. Yes, so the previous Chief Inspector for Children and Young People retired in June of last year, but because the organisation was undergoing a restructure, the responsibilities from her post were given to another existing Chief Inspector, who then went on maternity leave and it became a full-time job on a temporary basis and that job hasn't been restructured yet because the person's on maternity leave, so she needs to return to work before they can consider the longer-term plan for that post.
Q. Okay. Then if we move over the page, please, to page 6, where in section 3 we are looking at policy, procedures

and approach in relation to the establishments that we're looking at in the context of this case study.

First of all, in relation to policies and procedures, at paragraph 3.1.1, as I understand it, there's no difference in relation to policies and procedures. We'll come to approach separately, but in terms of policies and procedures --

A. For our policies and procedures, we would have -- yes, so we regulate based on service type as set out in schedule 12 to the Public Services Reform Act, so our approach to care homes or school care accommodation services would relate to the service type as opposed to who the service is being provided to.

Q. Then if we go on over the page, to page 7, and paragraph 3.2, you deal there with inspection approach, where children have long-term healthcare needs, additional support needs and disabilities.

Are there differences in inspection approach?

A. The inspection methodology and frameworks that we use are based on service type. So whether it's a care home or a special residential school, for example, but in terms of what we look at on inspection, we would want assurance that the service has employed people, for example, with the necessary skills, knowledge and experience to support the young people that they're

caring for, so if those young people have additional support needs, there might be particular training expectations or other procedures in place that would support staff to do their job and make sure those young people were appropriately cared for.

Q. At paragraph 3.2.1, you note there that inspectors take account of the specific needs of children and young people when carrying out inspections, and, as you say, you would want assurance that the children and young people's needs are being met by the staff who are in the service. How do you ensure that inspectors know what the needs of the children in these particular settings are?

A. So usually we would know prior to undertaking an inspection, so we would have a knowledge of the service, either from the existing case holder or the previous case holder. Sometimes services might have detailed, as one of their conditions of registration, who the service is provided to, but that's not always the case.

So we would generally know who the service is being provided to. Having said that, that's not always the case. We might turn up to inspect a care home and there be an autistic young person being accommodated since our last inspection that we weren't aware of, so although we

often know who the service is being provided to, that's not always the case.

Q. If someone were to turn up to an inspection and find that there was, as you say, an autistic young person there, how would that change the inspector's approach?

A. So a lot of our approach is designed to increase the engagement of young people, whether or not they have a disability, and there's a later section in the report that talks about ways that we've tried to increase engagement with young people, both with communication needs and more broadly.

So a lot of our pre-inspection information would be relevant, regardless of whether or not the child has communication needs. One of the first things that we ask when we arrive in a service is if there is anything that we need to know in terms of risks presented by or for young people or any difficulties that young people might experience with us being present and for some autistic young people, they might find having a stranger in their house a difficulty, but equally, other non-autistic children might have the same difficulty.

So we would expect to receive that information on arrival and obviously we would take that into account in terms of how we engage with young people. To have a knowledge of the young person's interests and the ways

in which they communicate is obviously helpful to our inspectors in terms of being able to engage successfully with young people.

Q. Then in the next page, page 8, at paragraph 3.2.2, you go on to talk about the requirement for inspectors to communicate effectively with children and young people experiencing care. Obviously in this context, inspectors may encounter children with a range of communication differences and therefore approaches have to be tailored accordingly.

You go on to explore this a bit further and in looking back to the period over 2002 to 2014, at paragraph 3.3.1, you note:

'The challenges of seeking the views of young people during and between inspections, and when they have concerns to raise, is significant.'

Can you explain that a bit further, please?

A. So there are a number of factors there.

One is thinking about the relationship that young people have with us as the regulator and we know the importance of relationships in supporting young people to engage, to communicate, to potentially disclose information and it's difficult to establish a trusting relationship with an inspector who potentially shows up once a year for a couple of days.

LADY SMITH: And I suppose it's not always the same person?
A. That's correct. We do, as far as possible, try to keep an inspector with a service for a few years, but there's a balance to be had between consistency and relationship building and regulated capture, which I know we've spoken about previously, so not having the same inspector with the service for years and years.

We try to engage with the service informally so if they were having like a barbecue or that kind of thing, for an inspector to go along and engage sort of informally with young people, but obviously our resources are limited and that's not always feasible, depending on where the service is located and what other work the inspector has on.

So, yeah, I think there's difficulties there for children more broadly in terms of whether they feel confident to speak to us or to speak to us openly and honestly and to have trust in the inspector. That's why it's so important that we're able to engage with other stakeholders. So social workers, for example, family members, children's rights officers, advocacy workers, who might have really important information about how the child is doing in the service and how they are experiencing the service that they can share with us, because they might be able to speak on behalf of the

child, as it were.

Then, I suppose, alongside that, for children who have additional communication needs, they might communicate in very specific ways, even for the most skilled inspector, who is able to utilise a whole range of communication tools, unless you know the specifics of that young person's communication methods, you might not be able to communicate with them effectively.

So sort of what I was saying earlier about having that information from the service, if we arrive and the service can give us some direction about ways in which that young person communicates, that would obviously be of benefit to us in engaging with the young person.

MS INNES: Carrying on in this paragraph, you note that the challenge might be greater with children with additional communication needs, as you say. You say:

'Historically, we use paper questionnaires for children and young people, which in their time were a positive development, but the challenges for young people to understand and complete these, when being distributed by the service, are evident.'

Can you explain that a bit further?

A. So one of the difficulties was that they were paper-based and we know that young people generally have a preference for more sort of technology-based

information and the questions were also fixed. We weren't able to change them because they were printed, so the way that the questions were worded weren't always accessible for young people and didn't necessarily elicit the information that we would have found helpful.

Q. Then going on over the page, obviously speaking to young people is an essential component of inspection activity, but the Inspectorate recognises, I think, that there were -- it goes on towards the end of that paragraph at the top of page 9, to acknowledge the limitations of past engagement and further improvements that were needed, and we'll come on to that, but there seems to be an acknowledgement that perhaps communication with children wasn't what it might have been in the past?

A. Yeah, so we've explained previously that we used to have -- our inspectors used to hold generic case loads, so we didn't have inspectors employed specifically for children and young people services. They would carry a caseload of, for example, nurseries and care homes for children and care homes for older people. So in terms of specialist experience, they wouldn't necessarily have had that.

Then, additionally, not all of our inspectors will have a background where they've worked with people with communication differences. So we try to employ

inspectors with a range of experience and some of our inspectors have that as part of their background but not all of them, so we've done a lot of work to sort of upskill the team to try and ensure that people have at least a baseline, I suppose, a level of knowledge in that area.

Q. If we go on to section 3.4, which is looking at current practice and engaging with children and young people. As you've already noted, there are inherent limitations on a young person engaging with an inspector and therefore you are looking to trusted adults.

I suppose the question that might arise in relation to that is: how does the Inspectorate ensure that it is engaging sufficiently with these trusted adults?

A. So we use questionnaires for adults as well. We have a questionnaire that goes out to families and we have a questionnaire for external professionals, so that might include social workers, advocacy workers, as I say, there might be health professionals involved, depending on the service type and the young people.

So the questionnaire goes out, obviously the response rate for that might be varied. We have undertaken a piece of work to try and increase the response rate from social workers in particular because we know that social workers are really busy but we were

finding that the response rate was really poor and we felt that they -- it was likely that they would have really important information that they could share with us.

So just a few weeks ago, we released a video that's been -- we did a piece of work with two local authorities to try and understand what the barriers were for social workers and one of our inspectors developed a video and that's gone out to all local authorities and we hope that it will be shared as part of the social workers' induction, kind of, ongoing learning and development and with commissioning teams as well, to help them understand our role and the importance of them sharing information with us.

In the questionnaire, there's the opportunity for them to leave contact details as well. So not just social workers, but family members, so we might follow up with a call, or a text, or an email communication if that's preferable to them, to just get a little bit more information, so we would normally, sort of, sample some of the questionnaire responses by contacting those people directly.

LADY SMITH: Charlotte, a few moments ago -- sorry to take you back to a previous question in the response -- you were talking about the challenge for inspectors of

working with young people and children who have communication differences. You said that you've done a lot of work to upskill the team to try and see that they've got at least a baseline, recognising that not all inspectors will come to that work with any background in it.

What is it you've done to upskill the team? I would be interested in that, can you tell me?

A. So we've done a number of pieces of work. I'm trying to think where we started with this.

I think maybe in 2019 we had some -- an in-person learning and development input where we spent the day talking about different communication approaches, so things like the use of visual symbols, the use of sign language, the use of object signifiers, so the types of communication that would support verbal communication.

Since then we have developed the use of a social story that goes out with the pre-inspection information for every children and young people inspection. So the inspectors individualise those, so the text is generic, but it's individualised with the inspector's picture, so that goes out to the service and it's designed to give the young people some sense of what to expect from the inspection and the purpose of a stranger showing up in their house and, you know, to have a picture of them as

well can be helpful for some young people.

We revisited -- sorry --

LADY SMITH: Do you do any in-person courses for the inspectors on this particular matter?

A. On communication?

LADY SMITH: Yes.

A. So -- yeah, we had the in-person day in 2018. A lot of our training since then moved online during the pandemic. I think in January 2023 or it might have been 2024, we did another session on communication and then, more recently, inspectors have undertaken Talking Mats training, so that was done -- the first session, I think, was in October and the follow-up was in February. So Talking Mats is a specific communication tool designed to support young people to share their views about a particular topic and we felt that Talking Mats was of potential significance for inspectors, because, essentially, they're going into a service and they want the views of young people about their experience of the service and so Talking Mats is one way of supporting young people to be able to --

LADY SMITH: Sorry, this is language I don't know about. Talking Mats?

A. Talking Mats.

LADY SMITH: What's that?

A. It's a visual system, so you would use symbols and, ordinarily, you would decide on your topic, so if you wanted to talk to the child about activities, for example, that would be your topic and you would have a range of symbols that represent the different activities and you essentially have a mat on the table that can be split either into sort of 'Like' and 'Don't like', 'Yes' or 'No', like a positive and negative or sometimes you might have an 'Okay' or a 'don't know' option as well. So either two or three sections and the young person would put the activities, if that was your topic, into: 'These are things I like', 'I'm not sure about these', 'I don't like these', but you could use that for any given topic.

So we felt that that was a way that inspectors might be able to engage and elicit the views of young people who perhaps prefer to communicate through the use of symbols rather than verbally.

LADY SMITH: Thank you.

Thank you very much.

Ms Innes.

MS INNES: Thank you, my Lady.

If we can just look at pages 28 and 29 of the report. I think we can see there relevant extracts of learning and development and this refers to other

aspects, as well as communication, but I think that these were areas of learning and development which inspectors have undertaken, which the Inspectorate thought were particularly relevant to this case study?

A. That's correct.

Q. So for example, we have communication methods on 10 July 2019 and there's a webinar in April 2020.

That refers to 'Boardmaker' and you do refer to this elsewhere in your report so perhaps if you can explain that as well. You refer to 'Boardmaker Online'. Can you explain?

A. Of course. So Boardmaker is an organisation that produces a range of symbols, so I've mentioned symbols a couple of times, symbols are essentially just a visualisation of a word, but it's a commonly used system by most children, I would say, with additional support needs.

And we purchased Boardmaker Online, I think, in 2019 as an organisation and it's essentially just an online version of the Boardmaker tool that allows you to create symbols and the webinar was for inspectors to be able to learn how to use Boardmaker, because it requires a certain level of knowledge to be able to go in and create the symbols that you might want to use.

So those symbols then -- I mean, you could have them

in a digital form on your phone or tablet or something, but quite commonly they would be printed and laminated, so you might have them on a little keyring on you or you could have them printed to use them for the Talking Mats. Some children will use them in a communication exchange for Picture Exchange Communication System, which is often shortened to PECS, but that would only be relevant if a child has been taught to use PECS, so it wouldn't be necessarily the case that an inspector could use it in that way with every young person, but essentially they offer a symbolic visual representation of the spoken word and for young people with communication differences, it can be particularly helpful because it's concrete and it's there and you can refer back to it. So sometimes trying to hold the words in your mind and process them at the same time can be really difficult and having a visualisation of that, that you can refer back to can help support understanding.

LADY SMITH: So does Boardmaker produce the sort of symbols that you might, for example, find in an easy read version that an organisation might use to explain its processes?

A. Absolutely, yeah.

MS INNES: From what you just mentioned about

a communication style that a particular young person might use, so that goes back to you saying about the importance of engaging with the service, so that you know what communication method a child or young person might use.

A. Absolutely, yeah. It's the same with sign language. You know, there would be no point in using sign language with a child who hadn't learned sign language, so I'm not talking about British Sign Language for deaf children, but Makaton or Signalong that's commonly used for children with disabilities, if the child hadn't been taught to use that mode of communication, then an inspector using it, it wouldn't be worthwhile.

Q. If we go on over the page just in terms of the training, on page 29, again towards the bottom half of that page, we see training on 11 January 2024 on increasing understanding of neurodiversity and additional needs.

Then in October 2024, 'Enhancing the way in which we engage with young people with quieter voices', and that was the Talking Mats training you mentioned?

A. That was the first phase of it, yeah.

Q. Just while we are looking at these pages, we can see that there were other relevant training issues, for example, in relation to restraint and issues in relation to that?

A. Yes.
Q. If we can go back, please, to page 10 of the report, and we've dealt with some of this already, but at paragraph 3.5.1, you say that inspectors use a variety of augmentative and alternative communication methods, with the aim of encompassing a total communication approach. What's a total communication approach?
A. A total communication approach is essentially a toolbox of communication options. So in a well-performing service for children with communication differences, I would expect them to be using a total communication approach. So they would have, as I've said, you know, symbols. They would -- their staff would be skilled in signing. They would use objects of reference or object signifiers, so, for example, showing car keys would mean that we're going out for a drive, showing a towel would mean it's bath time. These type of things that support children's understanding.

There would be visuals on the wall of, like, staff who were on shift that day. So the full environment would be supported by a range of different communication methods that young people could tap into as appropriate, depending on their communication style. And I suppose that's what we're aiming for in terms of the range of communication methods that we've been upskilling

inspectors in and so that whatever service they go into, they're more able to engage with young people, whatever their communication style.

Q. Then you refer to various things that you do, so at (a) a poster for residential childcare. Would that be for all services?

A. Yeah, yeah, that goes out to all services with our pre-inspection information.

Q. Is that visual or does it have a lot of text on it?

A. It's fairly brief in terms of text. I think -- I've not looked at it for a while -- I think there's some visuals on it, but it is for all service types, so it's not using Boardmaker or anything like that.

Q. Then at (b) you refer to the social story which you mentioned a moment ago in your evidence. You said that would include, for example, a picture of the inspector. Would I be right in thinking that you provide this to the service and then the service would use the social story with the young people?

A. That's right. So yeah, it would go out as an attachment to the service and it would be for them to share it with young people. So it's really just designed -- social stories are designed to sort of give an explanation of social situations to support understanding. So it's designed to say: this person is going to be visiting,

this is why they're visiting, if you want to speak to them, these are things they would like to know about. You don't have to speak to them, it's okay, kind of thing. So to give some information and some reassurance. So there are visuals throughout that social story, including the inspector's photograph.

Q. Then at (c) you refer to a video animation?

A. Yes.

Q. Is that for all services?

A. That's for all services, yeah. Again, it's just a short animation designed to explain the role of inspection and why these people are showing up at the place that you live. That's for all services.

Q. Then (d) you refer to Boardmaker Online, Talking Mats and PECS, which you have already referred to?

A. That's correct. We're also looking at developing a video this year, just a short video of the inspector introducing themselves and saying, 'I'm going to be visiting the place that you live', and -- so similar to the social story but in a video format and we would send that out to all services as well. So we're hoping to do that over the course of this year.

Q. If we go on to the next page, page 11, you talk about an addendum to regulatory procedures for children and young people.

If we look, please, at page 25.

LADY SMITH: That's in appendix 3?

MS INNES: It's appendix 3.

Is this something, as the name suggests, that's been added to the regulatory procedures for this year?

A. Yes. So that would have been from last year, although it will have been continued into our 2025/2026 inspection year. So we have sort of generic procedures for inspection and then additional considerations for children and young people inspectors.

Q. Do you know how this changed from previous years? Was it significantly redrafted or not?

A. We only developed the addendum I think in maybe 2023, I think off the top of my head. It's certainly been over the last maybe three, two or three years. So it's a fairly recent development. I suppose in recognition that there were particular things that we wanted inspectors to have awareness of when they were inspecting children and young people's services that weren't relevant to be included in the broader guidance and also that we had a variety of different notes and policy decisions and emails that were sort of not collated anywhere, and so we pulled them together into this one document as a way of inspectors being able to refer back to that, thinking about ways in which we

could respond to the recommendations in The Promise. We're always trying to work to increase consistency as well, so we had undertaken a piece of work during the pandemic, I think, with the team thinking about: how do we start an inspection? So we were finding that inspectors took different approaches when they arrived in a service. Some were going straight into the manager's office. Others were saying, 'No, it's really important I speak to young people first'. So we wanted to try and give services a consistent sense of this is what will happen when the Care Inspectorate show up.

So we'd done a piece of work with the team thinking through what would best practice look like and this was part of the work that came out of all of that.

LADY SMITH: Charlotte, I see what you're trying to get your inspectors to do in that first paragraph in appendix 3, because you don't want to give the children the impression that the inspector's principal interest is in talking to the adults who run the place.

A. Yes.

LADY SMITH: But you do note, of course, that you have got to speak to the manager to risk assess contact and communication with young people, but how do you avoid that falling into the trap that you try to tell the inspectors not to fall into?

A. That's the thing. It's a difficult balance, because if we just went straight in and started chatting to young people --

LADY SMITH: That's irresponsible.

A. Some young people might find that really difficult and we would need to know about that in advance, so that we can sort of tailor our approach accordingly. So we try to just have a brief chat with the manager to get any sort of immediate information that we know, and, of course, if the inspector knows the service, it might be the same young people who lived there the last time they visited and they might have some prior knowledge as well, so it would just be a quick update.

LADY SMITH: Is any advice given to the inspector as to how to have that brief word without it seeming to the children that talking to the manager is the most important thing to do? For example, are the inspectors advised, 'If you can, just speak to the manager in the hallway, so the children can see you', if they're around at that time, 'Don't go and speak to the manager behind closed doors', that sort of thing, is that possible?

A. They could do, I suppose it would depend on confidentiality of information, if there were particular pieces of information that the manager wanted to share that wasn't appropriate to do in front of young people.

I suppose it depends where young people are in the house when the inspector arrives or, you know, they might be out at school as well, or out on activities and things, so, yeah, there's a whole range of factors, I think, to take into account. It's very complex, there's no kind of straightforward answer unfortunately.

LADY SMITH: No, I can see that. Some may just depend on the layout of the particular building. Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

That was the main issue that I was going to cover in relation to this addendum, so I'll go back to page 11, please, and paragraph 3.5.2, where you are talking in more detail about enhancing young people's participation and engagement.

At (a) you mention a question bank. Can you explain that, please?

A. Yes. It was developed, I think maybe around 2020. We had a lot of new inspectors join the organisation round about that time and I suppose, again, thinking about consistency of approach, we had a focus group of inspectors set up where we thought for each of the key questions what are the types of questions that we would ask young people to sort of support young people to tell us about what we want to know in relation to that key

question.

So inspectors just shared the types of questions that they would normally ask and we collated them into a document under each of the key questions, so that -- I mean, it's not an expectation that inspectors have to follow it, but it's there as a prompt or a support if they need that in terms of supporting them to ask children questions.

Q. Then at (b) you refer to a 'text to complain' service.

A. Yes.

Q. Can you explain that a bit further?

A. So that came about, because we recognised that we get a very low number of complaints directly from young people. That's always been the case and we suspect partly that that's about the trust in the relationships that I spoke about earlier. It might be that young people feel that they've got other people in their lives who are more trusted, that they want to speak to.

Sometimes I think young people don't want to complain because they're worried that that might mean that they have to move on, so it might not be the best place they've ever lived but also it might not be the worst, and so it's better to stay quiet and stay where they are and we see that in some other service types for adults as well.

But we wanted to offer young people a way to complain that was more accessible and we recognised that our method of email and using phone contact might not be young people's preferred mode of communication, so we developed a text service where they could text a number if they wanted to raise a complaint about the service. Alongside that, we developed an animation that told young people about the text to complain service and there was a poster as well that services could display to let young people know about the text to complain service.

We are in the process of refreshing that, I suppose, in recognition that most young people probably aren't texting now either. The initial piece of work was done a few years ago, so we would hope to move it forward again to something -- I don't know what apps young people are using at the moment, but something that's more current for young people.

Q. In terms of the video animation, is that on your YouTube channel?

A. Yes, it's on our YouTube and it's shared with services, but we can share it with young people directly and we ask our inspectors every time they're in a service to let young people know about this as well, so that if they're thinking, 'I'm not happy and I want to tell

somebody', you know, it might be in the back of their minds there that they could contact us.

Q. Have you found that young people have used the service?

A. We have had young people use it. We've also had a number of young people supported by advocacy organisations to contact us as well, which is really positive, I think, that they were able to get that support to be able to contact us and raise a complaint.

Q. Sorry, I should have asked this earlier when I was asking you about trusted adults. So a young person might have an advocacy worker, for example, or a children's rights officer, how do you know who to send your questionnaires to? Are you reliant on the service to do that for you?

A. Sort of. We were, and then we moved to a position where we were asking the service to send us the contact details of all the external professionals and we were sending them out ourselves, which meant if we weren't getting a great response rate, we could chase that up.

However, we're in the process of temporarily moving to a new platform that won't allow us to do that, so we are going to have to revert to sending them to the service to send out, but we've got a longer-term digital move in place that I think is due to happen in about 18 months, where we'll move to a new platform entirely

that I'm hoping will give us much more accessible options for this and also for engagement with young people more broadly as well.

Q. Okay. Then you refer at (c) to online questionnaires, which we have spoken about, although here you talk about revised questions to enhance accessibility. I think you said earlier in your evidence that the questions previously hadn't been that accessible?

A. So we've been using Microsoft Forms for the online questionnaires for the last few years, which is a step forward, I think, from the paper questionnaires but ultimately not where we want to be. I would like to have a method of questionnaire that's more accessible, more visual and just feels more current to young people, I think. But one of the benefits of Microsoft Forms has been that we can change the questions, so on an annual basis, the team have reviewed the content of those questionnaires and we've changed them if we felt that we maybe weren't getting the information that we needed from them or maybe they could be worded in a way that was more accessible for young people.

Q. Then at (d), you refer to having key messages section of inspection reports, which provides an accessible summary of your findings. This would be in written form on your website?

A. That's right. So as part of the full inspection report, the first or second page just provides a summary of the findings, so again sort of thinking towards the future, I would like something more accessible, supported with visuals, but as an interim step from where we were with our inspection reports a few years ago, it provides that overview without having to read the full report, if that's a barrier.

LADY SMITH: Charlotte, do you ever discuss what the extent of your audience is? I'm talking about when a report is published. I wondered if you discuss with your inspectors, with the authors of the reports and the people who organise the publicity for them, the wide range of individuals who may have an interest in reading them and need to understand them. Do you do that?

A. There has been some work done around that, yeah. The -- we have quite extensive report writing guidance and a toolkit for inspectors that's been developed by our methodology team and that's all been -- I think the current toolkit that we're using I think was developed a couple of years ago but it's been kind of reviewed on an ongoing basis, so there's been quite a lot of work done in relation to inspection reports but again, I think it's part of that journey and I think there's probably more that we could do there.

LADY SMITH: The reason I ask is because, off the top of my head, I can immediately think of a range that at one obvious level is government, and both central and local authority government plainly will want to read it, and read it as an intelligent adult would want to read it, but at the other end of the scale, if you're serious about communicating with children, children and young people who are the users of the service and may have great difficulty in understanding complicated language, however simple the author thinks that it is.

A. Yeah.

LADY SMITH: Maybe then get to whether you should think of an easy read version of your reports to go alongside the report that goes out for government et cetera.

A. Absolutely, and that's -- I had mentioned the digital transformation that we're undergoing, but that will move the inspection reports from the current system to this new system and I would hope, as part of that, that we could look at something. Because we're not just talking about children and young people. We're talking about adults with learning disabilities, older people potentially with dementia, very small children, so there's a whole, you know, range of service types that's bigger than just my team, that I think would benefit from having a more accessible, kind of, easy read

version, as you say.

LADY SMITH: An example that also comes to mind that I'm familiar with is how over the last, I suppose over the last two decades or so, since they first came into being, the original support needs tribunal, which is now an element of the health and education chamber of the Scottish tribunals, has improved the accessibility of its output, its website, its newsletters, its reports -- gone through great transformation and I think very effective in achieving accessibility, insofar as is possible, in what's really a very complicated area.

A. Yeah. Thank you.

LADY SMITH: Ms Innes.

MS INNES: Thank you, my Lady.

In terms of feedback to children and young people, you mention a pilot project, which probably is linked to what we've just been talking about and you talk about including face-to-face verbal feedback or a video of the inspector providing verbal feedback or a bespoke poster.

You say it's a project that's a pilot at the moment, can you tell us a bit more about that?

A. Yes, so it's been ongoing for the last couple of years and we're just gradually upscaling it, so it's still ongoing. So we started in care homes and this year, we're hoping to extend that across a range of service

types, thinking how will this approach work in mainstream boarding schools, for example, who might have 600 children living there or in secure services, who might have, you know, 20 children. Or in services that maybe the outcome of the inspection has been really poor, so the feedback from the inspection might be quite difficult.

So that's our, kind of, plan for this year, but in terms of what we've done to date, yeah, we've got that range of options so we've got a sort of decision-making tool to support inspectors with thinking about what is the most appropriate option here and it might come down to young people's preferences. There might be an element of resource implication in there, because if the service is very far way from the inspector and it would require them to travel back to the service, it just might not be feasible for them to do that face-to-face feedback.

So we've got that range of options there, depending on a range of factors, but we've had really positive feedback and I think it's another way of making the findings of the inspection accessible to young people, but we're, I suppose, proceeding with caution because we recognise that it can be really difficult for young people to hear potentially negative feedback about the

place that is their home, that they might not have experienced in that way. So our findings might not necessarily correlate with their experience as an individual.

I think we just need to think carefully through how we approach that in a way that is -- feels supportive for young people and doesn't lead to them becoming distressed by that.

Q. You mention a video there and I think on your YouTube channel, you do have some short videos providing findings from certain work, it may not be inspections --

A. I think there are strategic inspections that go on our YouTube channel, so these would go on our YouTube but they would be private, or whatever the term is, that means that they can't be viewed by anyone. So they would be sent out, but not sort of available for public viewing.

Q. So if you were carrying out a strategic inspection, a broader inspection of a particular general service in a particular area, for example, that would be on your public channel?

A. I'm fairly certain that the strategic inspections are usually undertaken of local authority areas and we would publish a report, but they've been producing videos of findings for young people for a number of years and

I'm fairly certain that they're publicly available, yes.

Q. Then at (f) you refer to the involvement of young inspection volunteers and you've told us about this before in evidence to the Inquiry and the participation of those volunteers is gradually increasing?

A. Yeah. So we had a reasonable number undertaking and taking part in inspections prior to the pandemic and we found that number dropped off, just young people had moved on, you know, they had job opportunities and college opportunities, which is great for them and not so great for us.

But that meant that we had to undertake quite a significant recruitment drive, so we've been increasing the number of young inspection volunteers and alongside that gradually increasing the number of young people who are taking part. So we've got quite a focus on that this year in terms of trying to increase the spread across the team.

Q. If we can move on, please, to page 12 and section 4 of the report. This is where the Inspectorate provide us with information relevant to abuse and maltreatment in the particular establishments being looked at in the context of this case study.

If we can move on to page 13, at 4.4.1 you refer to summaries for each of the services listed. If we just

go down to 4.5.1, you refer to a particular establishment, Woodlands School, which was registered in the category of school care accommodation from 1 April 2002 until its closure in August 2004?

A. Yeah.

Q. Now, in this part of your report, you note that there was perhaps a lack of detail in terms of the records that were available?

A. Yes.

Q. If we go on to 4.5.2, you note there that there were concerns about the physical premises and the suitability of it and a complaint made by Fife Council?

A. Yes.

Q. Then you note that there was a voluntary embargo in admissions to the service and then the service went into liquidation and closed in 2004?

A. Yes.

Q. And you also note at 4.5.3 that there was a note on record about a concern expressed by the local police?

A. Yes.

Q. Now, we're going to look at the detail of some of that and we're going to start looking at the documents for Woodlands. Just bear with me a moment.

The first document we're going to look at is CIS-000010578. If we look at page 2 of this document,

I think we can see that this complaint was logged on 20 May 2002. If we go on to the next page, in the substantive paragraph, we can see there that it says:

'Fife Council are concerned regarding the care of an individual at the school. Physical restraint is being used resulting in a resident being bruised. Another instance being a staff member that was charged with assault. Staff visited the school [I think this is staff from Fife Council] --

A. I think so --

Q. -- visited the school on 14 May 2002 and found it to be in a chaotic state, the young people were beyond staff control and the police were called. Fife Council have decided not to place further young people in the home and are taking out and finding alternative care for four residents already placed there.'

So this seems to be an example of an issue being raised directly by the local authority?

A. Yes.

Q. Is this one of the reasons that you would look to social workers to provide you with information, as you've mentioned?

A. Yes, so not just at the point of inspection, although we do use questionnaires, but if social workers or any professionals come across concerns in the course of

their work, in their engagement with the service, it's really helpful if they make contact with us to let us know about those concerns, because, outwith inspection, we rely on information being provided to us. In a good service, that information will be provided to us by the service, they will let us know about incidents and, you know, notifiable events, but that isn't always the case and so it's really important that professionals or family members, or members of the public sometimes, are able to get in contact with us and let us know that they're really concerned about something and we can then follow up on that accordingly.

Q. In this case, there was an investigation carried out by the Care Commission, as it then was, and this is at CIS-000010580.

I think we saw that the complaint was dated 20 May 2002. Then we see a memo here, dated 29 and 30 May 2002?

A. Yes.

Q. So it would appear that the Care Inspectorate have taken quite swift action?

A. Yes.

Q. Would that still be the case if there was a report like that?

A. Yes, so when we receive information into our complaints

team, we triage that information and make a decision about how to respond to it and there are a range of responses, but one of them would be to go out and carry out a complaints visit.

So if it was information of concern, like that information was, we would ordinarily try to do that, I would say, broadly within the next week or so. Sometimes it might be as soon as the following day. It just depends on availability and location and other concerns that are ongoing at the same time, so always just try to sort of prioritise our resources in the best way.

Q. And here this -- at the beginning in the introduction, this tells us that Woodlands School was previously registered with Dumfries and Galloway Council, this would have been before the Care Commission came into operation, to provide up to 52-week placements for boys aged 7 to 17 who have identified emotional, social, behavioural and educational needs. That tells us a bit about the background of this service?

A. Yes.

Q. If we scroll down to the bottom of the page, we can see in the background, this is essentially in response to information from Fife Council.

Then if we go to page 3, we can see there is

a report there and under 'General comments', it notes some issues that were being addressed. Just above the heading 'Accommodation and resources', it says:

'It was noted that the management team at Woodlands expressed their desire to co-operate fully with the process of the investigation.'

Then, I think, the Care Inspectorate went on to investigate. One of the things that it looked at was the state of accommodation?

A. Yes.

Q. I assume that would be something that inspectors would look at still?

A. For care homes and school care, yes.

Q. We see at the bottom of this page, in relation to the state of accommodation, it refers to there being considerable damage to buildings. And we can see, sort of, five lines from the bottom there, it says:

'While young people openly acknowledged their part in causing the damage, they indicated that as long as the place looked and felt run down, there was little motivation on their part to refrain from further damage. One young person commented that, "When you live with broken windows, you don't think twice about breaking another".'

A. Yes.

Q. So I suppose that might say something about the importance of the environment for young people?
A. I think what we often find is that the environment sends a message to young people about how important they are, how well cared for they are, how nurtured they are. So yes, when the environment appears run down or not well maintained, that is sending a message to young people that they're not important enough to provide a nice environment for them to live in.
Q. Then if we go to page 5, at the top of the page it talks about toilet and bathroom doors having locks. There were difficulties in the past with this and the children and young people described how taking a bath or shower had been dependent on staff standing guard outside the door in order to ensure their privacy.

Again, I assume that issues in relation to privacy would be something inspectors would be concerned with?
A. Absolutely, yeah, privacy and dignity of all people experiencing care.
Q. Then if we move on to page 7, there's a paragraph beginning:

'A number of staff files were looked at during the visits. Mrs Reid shared her intention to recruit both qualified and experienced staff. It's noted that some of the newly recruited staff did meet these criteria.

Within the more established staff group, it is noted that few hold a professional qualification or relevant childcare experience prior to taking up post at Woodlands.'

She says that a number of staff had undertaken HNC training, but a considerable percentage had dropped out after experiencing difficulties with course material. Again, we know that training is important and that there are certain requirements.

Do issues in relation to resistance to training or difficulties with undertaking courses still arise?

A. Not to that extent. I mean, this was around the time that we really started trying to professionalise the workforce and I worked in residential childcare at that time, but there was a lot of difficulty, I think, for a workforce that hadn't experienced that level of qualification and training and need to register previously, and I think some people left the workforce as a result of that.

As Mrs Reid said, you know, people experienced difficulties with the course material and sometimes people just felt that, you know, that level of academia wasn't for them, you know, that they felt they weren't able to do an HNC, so I think that was a real issue for the sector at that point in time but I think, you know,

things have moved on quite considerably since then.

We do still experience difficulties with staff not being trained to the level that we would expect, but that's not always because of staff resistance or not even often because of staff resistance. Sometimes it's because the provider isn't offering the relevant training.

Q. Going down slightly further in the same paragraph, Mrs Reid is acknowledging that basic training is necessary and then it says:

'Supervision of staff continues to be sporadic, as highlighted in the last inspection report in September 2001. There appear to be few staff with relevant training and experience in relation to carrying out this function, a view which is shared by Mrs Reid, impacting on how this area can be addressed in the short term.'

Again, there's an issue here in relation to supervision of staff by suitably qualified people?

A. Yes.

Q. Again I assume that you would be looking at the qualifications of those in a more senior position?

A. Yes. So we would expect people who are operating in a supervisory role to have the necessary training and experience to be able to deliver that role and to make

sure that the staff team were appropriately supported, in order that they're able to appropriately support young people.

Q. Then if we can move to page 11 of this, in the paragraph just above 'Recommendations', it's noted:

'Staff and young people spoken with indicate that communication between carers and young people is not always carried out in a professional manner. Comments made to inspectors strongly suggest that some staff allow personal feelings to interfere with their professional contacts with colleagues and that young people aren't always addressed with an appropriate level of respect.'

Again, is that something that inspectors would continue to look at?

A. Yeah, we would be very concerned if we came across that type of practice now. I think that's a strong indication of the culture of the service.

Q. And then, if we move to page 13, there's a heading entitled 'Care and control'. Just pausing, I suppose using that terminology, is that terminology that has changed since then?

A. Yes. So care and control at that point in time would have been used to refer to restrictive practices, but it's not language that we would use now.

Q. If we go to the bottom of the screen at the moment:

'The incident report format used was examined and few show any analysis in relation to the root cause of the behaviour that led to the incident. These reports tend to be factual. There is an absence of alternative methods of intervention being employed, for example: de-escalation. On most occasions, a retrospective view by staff on action taken is limited to talking to young people or calming them down. There is no evidence of debriefing for either staff or young people. It appears that frequently staff are involved in physical restraints, and it is considered that this action could reinforce young people seeking attention through negative behaviour.'

There's a number of things within that and this is from 2002, but at that stage we're hearing about de-escalation and debriefing, so is that something that even from your own experience would have been expected at the time?

A. Absolutely. I mean, I think the area of restraint and restricted practices is really complex and there are so many factors that sit around it that impact on whether children have a good experience or not, or as good an experience as they can of being physically restrained, but our understanding of that and the

practice that sits around that has moved on significantly since 2002.

So yeah, if we came across this type of practice today, that would be a real concern for us, but at that point in time it was, I would say, probably fairly common.

Q. There's obviously also reference to recording and I know that the Inspectorate gave evidence on the last occasion about recording in relation to physical intervention.

But this also refers to the frequency of physical restraint and it's said that 'this action could reinforce young people seeking attention through negative behaviour', have you any comment in relation to that?

A. So there are a couple of factors there, I think. In relation to frequency, if you had a good system in place and you had debriefs and a good recording format and reflective practice, you would be reflecting on why the incident occurred and what could have been done differently and what might prevent that happening in future and you would hope that over time, that would show a downward trend in terms of frequency, so that's kind of what good practice would look like.

In relation to reinforcing young people's behaviour, it might be particularly if the culture that's sort of

described above was in place, that young people found that a way of receiving attention, albeit negative attention from staff, was to escalate their behaviour, which resulted in physical restraint.

It might also have been that they felt unsafe and it was a way of acting out that unsafe feeling and asking for support in managing feelings and behaviours that perhaps felt uncontainable to them. So seeking that sort of external containment of their own behaviours, not in a conscious way, obviously, but, erm ... yeah.

LADY SMITH: Charlotte, I'm puzzled at that sentence. Going back:

'It appears that frequently staff are involved in physical restraints and it's considered this action could reinforce young people seeking attention through negative behaviour.'

How could staff not be involved in physical restraints? Do you see what I mean?

A. Yes. I think it's probably not a very well-worded sentence, but it's trying to refer to the frequency of it, that we would expect perhaps that they would be less frequently involved than they were.

LADY SMITH: That there would be fewer incidents --

A. Fewer incidents --

LADY SMITH: -- requiring restraint.

A. -- yes, as opposed to fewer staff involved.

LADY SMITH: That must be what was meant.

Thank you.

MS INNES: Then the next paragraph it goes on to say:

'The recently drafted care and control policy was seen by officers who felt that it represented a list of sanctions which can be used if necessary. The document was considered to emphasise punitive measures of control and omitted any focus on positive intervention.'

Again, I assume policies would be looked at in relation to these matters?

A. Absolutely, and, I mean, the care and control policy; we would now refer to a restrictive practice policy or a physical restraint policy, but that's one of the key policies that we ask to see as part of services applying to register with us. So we would want to have sight of that before a service is even registered and obviously we would keep that under review as part of our inspections.

Q. If we move on to page 15, in the paragraph beginning:

'Mrs Reid has drawn up new child protection guidelines and 34 staff have attended a recent training course. However, there are still concerns with regards to the broader issue of safeguarding on both a physical and emotional level that require to be addressed. Areas

that should be looked at include: risk assessment, safe touch, values and attitudes, parenting skills, appropriate relationships, developing young people's awareness of personal safety, sexuality, et cetera. This list is not exhaustive ...'

So it looks like the Inspectorate were suggesting that there were a whole number of issues that needed to be addressed with staff?

A. Yes, that's quite a range of issues that are detailed there.

Q. And then if we look down below in the recommendations, there are a whole number of recommendations, some touching on the points that we have looked at. If we look at the second-last bullet point on the page, it says:

'An alternative method of crisis intervention should be identified. A training programme should be submitted to the Care Commission. This should identify the timescales necessary to deliver training to all staff.'

So would you still expect, if you identified a particular training need, the service to tell you what they were going to do about it, give you the programme and give you a timescale?

A. It would depend on the circumstances. So ordinarily, we would expect that a service would deliver training, as

required to staff, based on the needs of the young people that they were supporting.

If we were concerned about that, as a result of an inspection or a complaint investigation, we would either make a requirement or an area for improvement, depending on the seriousness of the training. In extreme circumstances, the service might be under enforcement and that would be ... one of the required improvements might be to deliver a specific piece of training or a range of training and we might expect, as part of the service's action plan, that they identify timescales for when that would be delivered.

Q. Then if we look on page 17 at the conclusion of the report, there's reference to the implementation of an embargo on placements as a means of enabling the necessary changes. The proprietor and head of care agreed this as a way forward and they were going to reduce the current numbers from 25 to 19 and it moves on from there.

Is an embargo in placement something that would still be done or not?

A. It can be, yes. If we have concerns about a service, for example, if we feel they don't have appropriate numbers of staff to safely meet the needs of young people or they've got young people living with them with

particularly complex needs who need a particularly high level of support or find it difficult to be around other young people, with a good provider we would have those discussions with them about our concerns and ask that they don't admit any more young people until the situation in the house is more settled, whether that's they've recruited more staff, a young person's moved on to an alternative placement, whatever the situation might be. And a lot of the time a good provider would agree with us on that and say, 'Yes', you know, 'We understand the situation in the house is really unsettled, we know that we need more staff in place and we won't admit any more young people until the situation is stabilised'.

LADY SMITH: Of course in this case, Charlotte, they had a placing council, Fife Council, having decided they were withdrawing the four placements that they had at Woodlands, which might have been a prompt to the embargo, one of the prompts to the embargo, I suppose?

A. Yes, and I assume that's why the numbers were reducing from 25 to 19, if Fife had made the decision to remove their young people from the service.

MS INNES: If we move on to CIS-000010573, we come to a report on a monitoring visit carried out by two members of the Care Commission on 27 August 2002, so it

notes that this is based on an interview with the director and manager. The purpose of the visit was:

'To assess progress made with regard to accommodation resources, policies and procedures, training and development of staff, communication, monitoring and reviewing, organisational structure and personnel.'

So a number of things that they were looking at.

If we scroll down under 'Introduction', there is a paragraph beginning, 'Due to financial shortfalls ...' It refers first of all to the embargo on placements, and then it says:

'Due to financial shortfalls caused by this, 16 staff have resigned or been offered either voluntary or compulsory redundancies. The officers were further advised that two local authorities were currently refusing to pay fees owed after withdrawing their children.'

It appears that following the voluntary embargo and the complaints, initially by Fife Council, this has then resulted in staff resigning, which presumably then has a knock-on effect on safe staffing levels for children?

A. Yeah, I think there's a number of factors there. It looks as though some young people from other local authorities have either moved on or local authorities

have maybe become aware of the concerns that Fife had and made the decision to withdraw their children as well. So there's that aspect of it in terms of the reducing numbers.

There's also the bit about which areas of the accommodation they are and aren't using and whether that's related to the accommodation being a usable space, 'cause obviously we had concerns about the sort of level of disrepair across the organisation and I know there was plans for the provider to move to a new accommodation as well. So that might have been part of it and then alongside that, staff leaving and sometimes that can be because, you know, if issues are being raised, either they don't like the change in culture or they're concerned about the direction of the service if they think -- or, you know, young people are moving on because it's not a very good service, so staff might choose to leave before the situation becomes worse.

LADY SMITH: I can't help but notice, Charlotte, in the second paragraph, it being noted that the director, this is no doubt the director of Woodlands School, asked if the Care Commission could assist with recovery of fees, and this is fees that two local authorities were refusing to pay. How could he have thought it was part of the Care Commission's role to assist in recovery of

fees?
A. It's funny sometimes the things that people think that we cover.
LADY SMITH: Well, it doesn't sound as though the director was particularly switched on, on all matters that a director needed to be, but perhaps it indicates a degree of naivety that could be more widespread than simply the business side of running the school.
A. Yeah, and that might have had an impact and ultimately them going into liquidation as well.
LADY SMITH: Yes.
Ms Innes.
MS INNES: Thank you, my Lady.
I think if we go on to page 9, just as an example of what's in this document. Here we have, 'Provide a high standard of care to young people' as one of the areas that they're looking at.
One of the action points was to devise and implement a code of conduct for all staff. It notes that young people had been involved in some initial discussions but it hadn't yet reached the draft stage and it's noted that the progress was unsatisfactory in relation to that.
However, if we look below, for example, at the safe and secure environment, there was to be new repairs and

monitoring system. That was completed and the progress in relation to that was satisfactory.

I think in this document the Care Commission go through the various action points and see what's satisfactory and what's not at that time?

A. Yes. What we would expect for any service that's got a range of areas it needs to address in terms of improving practice, is that they address the most pressing concerns first. So things like a safe environment might be one of the top priorities or having sufficient safe numbers of staff might be one of the top priorities or a particular training need for staff. These might be the things that we would expect that they address first.

Then other developments, like a code of conduct, might be a longer term piece of work for them that is still important, but perhaps not the most important thing out of everything that they need to do.

MS INNES: My Lady, I'm conscious of the time and I'm going to move to another document.

LADY SMITH: Charlotte, I promised you a break at 11.30 am if we were still going then. Would you welcome it now?

A. Thank you.

LADY SMITH: Thank you.

(11.30 am)

(A short break)

(11.45 am)

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

A. Yes.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

If we can look, please, at CIS-000010566. This is a report in relation to Woodlands School, dated 29 April 2003. If we go on to page 3, please, we can see that this is an integrated inspection by the Care Commission and the Inspectorate, HM Inspectorate of Education.

We can see that there was an inspection which took place in November 2002 and if we look down to the heading 'The school', it says there:

'Woodlands School provides education and residential care for pupils experiencing significant social, emotional and behavioural problems. Many of the pupils have considerable learning difficulties and a history of non-attendance or school exclusion.'

That is the description that was given of the type of service that was being provided at the school.

If we can go on in this report to page 7, and under

'Management', it says:

'The director and manager of the school had undertaken a comprehensive review of care and welfare policies, but much of this work still had to be implemented. The manager had initiated an evaluation of care provision using National Care Standards, however, supervision of care staff was not effectively organised and team meetings had been irregular due to staffing difficulties. Comments by staff indicated a high level of insecurity and low morale. However, the school was in the process of implementing a newly devised approach to induction and continuing professional development. Senior managers were committed to ensuring a more consistent approach to pupils' care and welfare.'

I think that picks up on some of the themes that we saw from the material from May and then August 2002?

A. Yes.

Q. If we move on in this report, please, to page 9, this sets out some recommendations for improvement, but then, I think, at the bottom of the page it sets out requirements, which were to be fully met by the end of June 2003. I think we're familiar with the language of recommendations and requirements in relation to the Care Inspectorate, but also in relation to joint inspection reports. Is that still used?

A. We use requirements and areas for improvement now, so areas for improvement were previously called recommendations, but it's the same concept -- other than that, the same concept applies, yeah.

Q. At the bottom of the page, the final bullet point talks about levels of staffing in residential units, to ensure that pupils and staff are safe and secure at all times.

If we go on to page 10, there's a bullet point, the first bullet point notes:

'The school should develop its approaches to risk assessment for pupils, beginning when pupils are admitted and keeping them under continuous review. Procedures should cover risks associated with the use of accommodation, group living, outdoor education and child protection.'

That covers a number of different types of risks. Would you still expect to look at risk assessments for young people?

A. Yeah, we would expect services to have a range of risk assessments, so in relation to the environment, for example, or particular activities that young people undertake, but also specific risk assessments for each young person, 'cause obviously different young people will present with different risks in different situations and appropriate strategies to mitigate those

risks for each individual young person.

Q. If we scroll down this page to the second-last bullet point, it says:

'The school should continue to improve the quality of training for staff in respect of its statement of functions and purpose and the implications for day-to-day practices. Further staff development should include the effective use of risk assessment and of control and restraint.'

I think that just follows from what you have just said, that you would look at the risk assessment because you would expect staff to use that and be aware of it?

A. Absolutely, and if you've got an effective risk assessment in place, that would not only reduce the risks to young people, but potentially reduce the level of restraint or other restrictive practices as well, because you would be sort of intervening before a situation reached a point that required restraint.

Q. We see that the final bullet point there notes that:

'Investigations of complaints regarding members of staff should be carried out without undue delay.'

I don't think there's any other context for this in this report, but again would you look at investigations of complaints in relation to staff?

A. We would look at the service's record of complaints that

they might be from -- I'm assuming when it says 'regarding members of staff', it's complaints from staff, but maybe it's complaints about staff and I'm not sure who the complaints are from, but regardless, it wouldn't matter, we would have an interest in the service's record of complaints and their ability to follow their own complaints procedure. Obviously we have a complaints function ourselves as well, so sometimes, if people aren't satisfied with the service's response to their complaint, they might come to us or they might equally come directly to us without complaining to the service first.

LADY SMITH: That statement, 'Investigation of complaints regarding members of staff should be carried out', would seem to indicate that it's where there has been a complaint about a member of staff, but it doesn't tell you what the source of the complaint is. It could be another member of staff, it could be a service user, it could be a relative of a service user or somebody else.

A. Yeah.

MS INNES: If we can move now, please, to CIS-000010557. Now, we can see that this is a letter from Woodlands School to the Care Commission, dated 1 April 2003. This was shortly before the publication of the report that we have just looked at, although after the visits that took

place, which give rise to it.

If we just scroll down, I think we can see that this is from Audrey Reid, the Head of Care. It says here:

'Further to recent emails, I am writing to remind you of the details concerning [this is a staff member]. In June last year, the staff member had went into a restraint on his own when a young person had been damaging electrical fittings with a metal wheel brace. I am enclosing a copy of the report prepared for the then inspection and registration team detailing events.

Since this time, the staff member has been working in an administrative role, mainly assisting myself in day-to-day matters such as telephone referrals, procedural matters and policy documentation. In addition [he] has responsibility for co-ordinating SVQ staff training within the school, he has also been on the TCI Training for Trainers course ...'

Just pausing there, do you know what TCI is?

A. TCI is a model of restraint, so there are a whole host of different models of restraint, so TCI is one of the commonly used ones in residential childcare services and CALM is another, but probably the other -- CALM and TCI I would say are the two kind of prominent ones in residential childcare, but there's over 100 different models in the UK. Some are much better than others.

LADY SMITH: I think I'm right in remembering TCI, Therapeutic Crisis Intervention, was the first on the scene in the 1990s?

A. Yeah, TCI and CALM were both around about the same time, but in the nineties, that's right.

LADY SMITH: Then CALM being Crisis --

A. It was originally called Crisis and Aggression Limitation Management, but they changed their name a few years ago because I think the association with crisis and aggression didn't feel comfortable with kind of changing language.

LADY SMITH: You say you could now count up to 100 different methodologies or different descriptions.

A. My understanding is there's over 100 different models, yes, but I would say in Scotland there's around five that are sort of the main models that we would see used.

LADY SMITH: Thank you.

MS INNES: Then in the final paragraph it says:

'In relation to the outstanding child protection investigation, the police have yet to speak to two young people who are currently placed south of the border. There have been no further developments and [a staff member] remains suspended on full pay.'

This is a different staff member from the staff member that's been placed on administrative duties. So

it's possible that this is the investigation that was referred to in the report that we have just looked at, but we don't know, I think is the bottom line, but there appeared to be two issues highlighted in this letter.

A. Yes.

LADY SMITH: It also suggests that the two young people must previously have been in Woodlands, they wouldn't be relevant to the complaint otherwise, but were taken out of Woodlands and placed somewhere south of the border.

A. Yes, I wasn't clear if they were English children who had returned home to England, 'cause I think in some other documentation it referred to them having English children placed into the service, and, of course, they're quite near the border, or it could have been that they're Scottish children who were then placed outwith Scotland.

LADY SMITH: But were in Woodlands --

A. Yeah.

LADY SMITH: -- taken away from Woodlands, something to do with this investigation, it would seem, and they're south of the border as at that stage, yes.

Ms Innes.

MS INNES: Thank you, my Lady.

Attached to this letter is a report, or investigation report, in relation to the restraint issue

which resulted in a staff member being placed on administrative duties. If we could look, please, at page 15, we see the young person's account of the incident, which in the second paragraph he says:

'I went into my room and got a wheel brace, hit a couple more lights, they burst, well, one did anyway. The staff member came running down, took the wheel brace off me and put me on the floor.

'I lifted my head up when in the restraint. He must have thought I was going to hit him and he hit me in the side of the face with his hand. I banged my head off the floor.'

That was the young person's account of what had happened.

If we go back in this report to page 7, the report notes:

'The need for an internal enquiry to take place in relation to this incident became apparent after a telephone call was received by myself on 7 May 2002 from a police officer from the local police station and the police were going to formally charge the staff member with assault.'

Then the Head of Care goes on to set out all of her investigations. If we just go to page 13, please, ultimately she concludes:

'There does not appear to be clear evidence of the staff member using excessive force during the restraint. The allegation made by the young person is, however, of a serious nature and must be viewed as such. I would not therefore support the staff member in allowing him to return to his duties as a team leader until such times change that the charge has been dealt with by the relevant authorities.'

Then under 'Recommendation', she notes that the staff member in the bullet points is to return to work and undertake administrative duties designated by the Head of Care. He would be office-based and not in a position where he has unsupervised access to young people:

'The situation will be reviewed when the assault charge has been dealt with by the relevant authorities.'

Do you have any comment on the approach taken here where there has been a serious incident which has resulted in somebody being charged and they've been placed on administrative duties?

A. So it's a complex situation, because from the description of the incident, the young person sounds as though they were putting themselves and other people at risk through their behaviour, so the staff member was justified in intervening and I think the letter makes

reference to them carrying out restraint on their own, as though that was the issue and actually that's not an issue, because there are plenty of restraints that a staff member can do on their own, although prone which it looks like, is what they used, is not a restraint that you're allowed to do on your own, so that might have been part of the issue.

There's also the issue of whether the member of staff used excessive force and obviously the young person's description of having their head banged back down onto the ground and whether that's an accurate description of what happened or just how it felt to the young person at the time.

But regardless, prone is a high-risk hold and shouldn't have been carried out by one member of staff.

The recommendations bit at the end though is conflicting, I think, because it's saying that they think that the member of staff acted in the young person's best interests and that they didn't use excessive force, but also that their behaviour was a concern, so it sort of conflicts itself. Then obviously the member of staff has at the same time been charged with assault. So the police obviously found something there, in terms of what had happened, with enough evidence to be able to charge him.

So I would have expected the service to be led by the police in that regard. So if the police have found evidence of an assault, that that would be sufficient evidence for the service to say that that member of staff is not appropriate to be employed in that role any more.

LADY SMITH: And perhaps needs to be at least suspended in the meantime?

A. So ordinarily we would expect the police to be allowed to undertake their investigations and/or social work and then the service to carry out their own investigation, so it might be that the police found no evidence of criminality, but we would still expect the service to undergo their own investigation and reach their own conclusions on that and that might include suspending the member of staff while they carried out -- depending on the severity of the accusations.

LADY SMITH: I just wondered what it would say to the children and young people that, although that member of staff wasn't doing the sort of work that he'd been doing before and able to be in the company of children on his own, he was still in the same working environment and they might not make the distinction and they were seeing that, although there was an investigation going on, which they were bound to know about, he was carrying on

as normal.

A. Mm-hmm.

LADY SMITH: It doesn't sound as though it was putting the children's interests first.

A. Yeah. I think it's a difficult balance. In terms of what we would expect now, we would expect the service to have a robust risk assessment around that, so, you know, the benefits of the member of staff being able to stay at work alongside the risks posed to young people of them doing so.

In some services and for some young people, there might be quite a high number of allegations, which might not always be accurate from young people, and so repeatedly suspending staff and not having them at work might be counterproductive to that, so it's a difficult balance, I suppose, in making sure that young people are listened to and their concerns are acted upon, but also making sure that you've got sufficient staff, you know, there to do the job in a way that's safe and people aren't unnecessarily suspended so ...

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

If we look at CIS-000010572. We can see that this is an inspection report from the Care Commission and we

can see that the date of the inspection was 7 May 2003. If we look on to page 3, and if we scroll to the bottom of the page under 'Basis of report', it says:

'This report was written following an unannounced visit by Care Commission officers on 7 May 2003. The inspection focused on progress in relation to the recommendations of the report following the investigation of the Care Commission in May 2002 of complaints made by a placing authority and an action plan compiled by the school in July 2002 in relation to that report.'

LADY SMITH: So that would go back to the Fife Council complaint?

MS INNES: It goes back to the Fife Council complaint and not to the joint report that we've just seen from the HMIE and the Care Commission.

If we look, please, to page 7. In the largest paragraph that we can see on that page, on the screen, at the end of that paragraph, the last sort of four lines of it, it notes that:

'It is a cause for concern that the start of a programme of training in relation to Therapeutic Crisis Intervention had been postponed due to recent pressure on staffing. It will be important to ensure that this is rescheduled to commence as early as

possible.'

It looks like there were still issues in relation to training, particularly in restraint to TCI?

A. Yes. I think one of the earlier documents we saw, there was a recommendation that they moved to a new model, so I think the introduction of TCI was part of that, but training a full staff team in TCI would have been a significant resource drain in terms of releasing them from their shifts to be able to undertake that training.

Q. If we look at page 11 of the report, in the second paragraph on that page it says:

'A staff member is presently under suspension following a complaint made following an incident involving control measures.'

That obviously can't be the staff member that we have just looked at, because he wasn't suspended, but we do know that there was a staff member who was suspended where the young people were now in England.

A. Yes.

Q. So it could be that person. It says:

'Investigation of this has been delayed due to external considerations, but the manager stated that she has identified a number of issues of concern arising from the incident, including the need for staff and managers to follow child protection procedures. She

stated that she has partially addressed these matters and intends to do so more fully once the investigation is complete.'

Then it mentions that another two staff members have been suspended due to breach of confidentiality.

Here it appears that the manager was seeing issues of concern in relation to child protection, some of which had partially been addressed and others would be addressed in the future. Do you have any comment in relation to that?

A. It's difficult, without knowing the detail, but if it's the incident with the children who were placed in England, when it talks about the investigation being delayed due to external consideration, that might have been the external considerations it's referring to and it might have been that that investigation was delayed because they were awaiting the outcome of the police investigation and perhaps there were actions that they were expecting to arise from the outcome of that investigation that hadn't yet concluded that they weren't able to enact on because that process was delayed.

But without knowing more around that, it's difficult to say if that's accurate or not.

Q. If we look down at the requirements, under (1), there is

a requirement to ensure that persons employed in the provision of the care service receive training appropriate to the work that they are to perform and suitable assistance, including time off work for the purpose of obtaining further qualifications appropriate to such work.

That seems to follow on the training needs that had been identified, but it also seemed to require people would need to have time off work to do that?

A. Yes.

Q. I suppose that would then have a knock-on effect for the staffing levels within the service?

A. Yes.

Q. If we can move on, please, to CIS-000010555.

This is an incident, a notification of a child protection incident, dated 27 May 2003. So shortly after the visits for the report that we've just looked at. The young person it can be seen, the placing authority is Darlington Council, which would suggest that children were being placed in Woodlands from outwith Scotland.

A. Yes.

Q. Then if we look at the details of the incident, it says that there was a violent and threatening situation that developed in the Uppers Unit in which all the young

people were involved. This became increasingly difficult for the staff to control, as a number of incidents occurred simultaneously:

'One of these was a potentially violent altercation between two of the young people who said they wanted to deal with it themselves. The senior on duty decided to allow them to go outside to do this. He knew that they were going to fight but felt that if he tried to prevent it then the general situation he was dealing with would escalate out of control. The fight happened outside and was resolved without injury to either ... person.

'The worker was waiting this morning when the director of services came in, he was very anxious and guilty about having allowed this to happen.

'I am referring this because his knowingly allowing this incident to happen, albeit in very fraught circumstances, may constitute a child protection issue. He has not currently been suspended.'

So would it constitute a child protection issue, allowing children to go and fight one another?

A. I think allowing -- knowingly allowing young people to put themselves at risk in a situation like that could potentially constitute a child protection issue.

LADY SMITH: One of them could have been killed?

A. Yes.

LADY SMITH: They're allowed to go outside, no adult there on the face of it, and they were all in a heightened state of agitation, having come from a very agitated group, to go there and to continue the fight outside.

A. Yes. I think this is one of a number of incidents in this service where the young people appeared to be outwith the control of the staff and sometimes it involved a number of young people being involved in an incident at the same time.

Having said that, staff are making really quick decisions in really difficult situations and it sounds like by the following day, Gavin had reflected on it and realised that actually he had made the wrong decision in that moment, but the decision about whether to intervene or not, whether to physically put hands on a child, all of that's made in a second, in a really heightened situation.

So sometimes staff do make mistakes and the important thing is that they reflect on that and learn from it and think about how they would do things differently the next time.

LADY SMITH: I can see that, but the service has to have a system that doesn't put a single member of staff in the position of having to make a split-second decision that could have obvious child protection implications --

A. Yes.
LADY SMITH: -- and the wrong decision, as it turns out, is made.
A. Yes.
LADY SMITH: It goes back to the responsibilities of the service to do its best to have a safe system in place; doesn't it?
A. Yeah, and the support available for staff in those situations.
LADY SMITH: But it's not a business of finding a culprit, a single culprit.
A. Mm-hmm.
LADY SMITH: Ms Innes.
MS INNES: Thank you, my Lady.

We're going to look at some other material that came to light over these months in 2003.

If we can now look, please, at CIS-000010581. This is a letter to the Care Commission from Highland Council on 2 June 2003. The author begins by saying:

'Following expressions of concern by Highland Council staff, and within the association of Scottish principal educational psychologists, Ian Taylor, Intensive Support Manager for the Highland Council, and I undertook an evaluative visit to Woodlands on Friday, 30 May.'

Then the author goes on to say that during the visit, they came to feel substantial concerns:

'... both about the standard of provision being made at the school and the school's response to the main points for action identified in ...'

And it refers back to the joint inspection report and certain issues are noted. At paragraph 3 it says:

'During our tour of the pupils' bedrooms, we were extremely concerned by some of the pictures on the bedroom walls of three pupils.'

If we go on to page 3, please, it essentially talks about sexualised images being on the walls and there's a paragraph beginning:

'Our concerns were further reinforced when we looked at the documentation for this pupil (who has been placed by Highland Council). Within the reports there are a number of references to issues of violence and sexuality and the difficulty of managing these aspects of this pupil's behaviour. There were references to staff being intimidated by him.'

Then they express concern about why things hadn't been done about this and they say:

'... or the fact that staff at Woodlands School do not seem to have made any link between this pupil's behavioural expressions of his sexuality and violence

and the imagery with which he has papered his room.'

Then they refer to, at paragraph 4, another -- they saw in another pupil's bedroom books on Hitler and the Waffen-SS:

'This pupil has an interest in the Warhammer gaming miniatures, some posters appear to evince an interest in fantasy. It has been our experience that some adolescent boys with these interests also give concern because of their violent thoughts and, as above, we are concerned that practice at Woodlands School do not appear to take any account of possible risk.'

I think that's going back to the issues about risk assessment that we looked at and the author was asking the Care Commission, so the author was the principal educational psychologist in Highland Council, and he was saying that the inspection team should give a high priority to monitoring the implementation of the statutory requirements set out in the previous report.

This is another example of a local authority proactively drawing issues to the attention of the Care Inspectorate.

A. Yes.

Q. Would these sort of issues that are highlighted in these reports, would these be issues of concern?

A. Erm, yes, so there was the issue of the posters in the

bedroom and -- could you scroll back up, sorry?

LADY SMITH: Is that far enough?

A. Up to points 1 and 2, I think, I can't remember what they were.

Not having care plans would absolutely be a concern.

The second point would be for HMIE or Education Scotland rather than ourselves.

The stuff around posters and what children choose to display in their bedroom, I wouldn't expect the service to remove those without discussion with the young person, but certainly to undertake a piece of work to support young people's understanding around why they're not appropriate or why they're offensive or the sort of broader impact in relation to -- I think they make reference to the young person's sexualised behaviours and that there might be a link there between that and the posters. So it might be that they needed specialist support through CAMHS, for example, in relation to the young person's sexualised behaviours or a particular focused piece of work on that.

But if that situation was to arise now, I would expect that to be sort of discussed in a multi-agency fashion and for the service to be saying, you know, this is an issue of concern and it's something that we feel the young person needs support with and for there to be

an agreed plan about how that was going to be approached and taken forward to support the young person with that, rather than sort of looking the other way, which appears to be what they were doing.

LADY SMITH: I think you second guessed my next question, which is: having recognised that and thinking about what to do, you would then expect to see something in the care plan to reflect the noting of the problem, the plan to address the problem, and how that's going to be implemented and appearing in the care plan, but if you're not doing care plans, it's not going to be there, is it?

A. Yes. For that to be reviewed. It might be a long-term strategy. It's not necessarily going to affect change overnight, but as you say, the steps towards how that's going to be achieved.

LADY SMITH: Thank you.

MS INNES: If we can look on please to CIS-000010563, which is a letter from the school to a staff member, dated 28 July 2003. This notes that following a disciplinary hearing, this is the decision. If we go down to the matters of concern, they include that he was sending text messages to the daughter of a parent, which indicated a secretive relationship with an underage child. So this is a person who is living outwith the

service.

A. Yeah.

Q. 'It was further alleged that you had kissed this young woman in the presence of other young people.'

And:

'That you had reason to believe that this young woman might have suffered from depression ...'

I think suicidal thoughts, and that he didn't seek advice on how to deal with the situation.

Ultimately, if we go on to page 3, we see that the conclusion was that the actions were essentially established and they amounted to gross misconduct and he was summarily dismissed.

So it appears that the service on this occasion took immediate action and dismissed this member of staff?

A. Yes.

Q. And obviously, although this was an incident in the community, it's obviously also relevant to his work with young people in the service?

A. Absolutely, yes.

Q. If we can look on, please, to CIS-000010558. This, as we see, is a letter from Dumfries and Galloway constabulary, dated 25 August 2003. I think we can see in the handwritten note, dated 3 September 2003, that a final warning had been given. It then says:

'Another issue last night involving the worker that we're going to speak about and a young person presently being looked at.'

That's what it says there. Then if we scroll down, it says that this is a report which has been sent by the police to the Care Commission. Would you get referrals directly from the police?

A. The police will sometimes contact us with information, so, for example, if there are high numbers of young people going missing from a service or placing themselves at risk by accessing a local train line or -- they might contact us to say that they're particularly concerned about that and that might prompt us to make contact with or visit the service.

Q. If we move on to page 3, we see the police report and we can see that the incident took place on 17 August 2003. We can see that there was an incident involving some young people and it then says:

'Whilst reporting the incident to the now accused ...'

The 'now accused' is the deputy unit manager, and it says that both young people got out of the car and sat on a wall at the front of the school:

'While sitting there they observed the staff member coming out of the school and making his way towards the

car. The young people were of the view that the staff member was in a bad mood. So they went and stood on a speed bump in the car park in front of where the car was stopped to prevent the staff member from driving into the car park area.

'The staff member then got into the car and began to drive towards where the two boys were standing. On approaching them, one young person stepped to the side but the other young person remained where he was.

'The staff member then slowed the car down but kept driving at minimal speed towards the young person. This caused the young person to inch backwards with the car almost touching him. The young person then heard the engine being revved and the car appeared to speed up slightly and, fearing that he was going to be struck by the car, he has jumped onto the bonnet.

'With the car still moving, the staff member has continued to drive the vehicle up the rest of the drive to the car park area with the young person on the bonnet.

'The young person has banged on the windscreen of the car and shouted at the staff member to stop. The young person then managed to jump from the moving vehicle and stumbled on the ground but landed on his feet.

'The staff member continued to drive the car the rest of the way into the parking area and stopped the car. He then got out and spoke with the young person and ascertained that he wasn't injured.'

And the young person asked that the matter be reported to the police, which then gave rise to this.

Then if we go on to page 5, it notes that the staff member attended on a voluntary basis and we see a paragraph beginning:

'It is the opinion ...'

So:

'It's the the opinion of the reporting officer that although no person was injured as a result of this incident, the possibility of the young person being injured was high.

'The staff member was of the opinion that due to the young person's well-known violent behaviour, that he was at risk when the young person jumped onto the car and continued to drive to deter the young person from assaulting him.'

That appeared to be the staff member's position. So do you have any comment in relation to this incident?

A. I mean, it's clearly a concern that the staff member thought that that was an appropriate strategy and appropriate that it was referred to the police for

investigation.

Q. Then, as we saw earlier, I think the staff member was given a final written warning following on this by the service?

A. So there had presumably been previous concerns.

Q. If we move on to another inspection report, this is at CIS-000010568. We can see, if we scroll down, that the date of the inspection was 23 October 2003 and it was an announced inspection.

If we look at page 5, we see in the paragraph close to the top of the screen:

'Progress continued to be made with staff training and development. Some staff still had to complete the TCI training which meant that there were still some staff who could not be involved in the restraint of a child.'

That was an ongoing issue, although progress was being made?

A. Yes.

Q. Then it notes:

'A staff member remained suspended pending the outcome of a police investigation of an allegation by a pupil. This had prevented managers from following up the matter internally. There were no other outstanding complaints and it was evident that such matters are

dealt with promptly.'

I think we have seen a couple of examples of issues with staff being dealt with in the intervening period, between the inspection reports?

A. Yes.

Q. If we look, please, at page 17, under 'Other issues', it notes there:

'Following the unannounced inspection in May 2003, it was decided that the embargo on new placements agreed back in 2002 should be lifted. It was also noted that the number of registrable places within the school had reduced and the school management was advised to apply for a variation in its conditions of registration. An application had been received to reduce the number of registered places from 25 to 15.'

We can see that the embargo was lifted and the number of places available in the school were also limited?

A. Yes.

Q. Now, in the Care Inspectorate's report, it also noted that there had been issues raised with the police or by the police more generally in relation to what was going on at Woodlands.

If we can perhaps look at CIS-000010546. This is moving into 2004, so this is a letter dated May 2004 and

it's a letter from Woodlands School to the Care Commission. It appears that there's an action plan to deal with some issues that were highlighted in a letter of complaint by Dumfries & Galloway Police.

I don't know if you can recall from looking at the information what the police's issues were in relation to Woodlands?

A. I think they had concerns about the high number of callouts, which is not an uncommon concern from the police in relation to care homes, and there was a particular incident that had occurred where they were called out and refused to assist, I think. That was one of the documents that was provided or that was certainly the account of the service, that the police had been unhelpful in their response.

Q. As a result of these issues, it then says on page 1 that there was a meeting with the chief superintendent, an inspector, a local councillor, HSO [redacted], who is the proprietor of the service, Audrey Reid, who is the Head of Care and 'myself, David Pithers', who we have already seen reference to and they had a discussion.

For example at 2, if they were requesting police assistance, they would have to clear that with a senior manager, except where an offence against the person or

their property was being made by that individual.

There seemed to be some discussion about when they would call the police out.

A. Yes.

Q. Then there was discussion about the police coming to visit and Mr Pithers conducting training sessions for local police officers to increase their understanding of the nature and needs of the people placed there.

If we go on, please, to page 3, at paragraph 3 it says:

'A directive to staff has been issued about the use of holding (restraint) in situations where a young person is radically unsafe or behaving dangerously. In debriefing discussions following recent events, it became clear that there was some confusion and even fear about this. During the summer break, a refresher course in TCI methods will take place and these will repeat and emphasise the principles of this directive.'

There appeared to be a link between calling the police all the time and staff using restraint in the service?

A. Yes, so it sounds to me, from point 3 there, that staff weren't intervening when they should be, so staff have a duty of care to keep young people safe and that means that at times they will be required to intervene

physically to prevent certain risks from happening, if a child was about to run in front of a car, for example, you would stop them and pull them back.

But it sounds as though, and it might be because of some of the historic issues around restraint, where staff had been suspended in relation to the misuse of restraint, that maybe that created a culture of anxiety around using it and it almost went the other way, that then staff weren't using it when they should be and were perhaps relying on the police instead to come and intervene.

LADY SMITH: Relying on the police to do what they should have been able to do themselves?

A. Yeah.

LADY SMITH: It's not dissimilar, although in a different category, to the plea being made to the Care Commission about needing help to collect fees that were due. They can't quite follow through themselves on what actually it's their job to do.

A. They should be doing, yes.

LADY SMITH: Ms Innes.

MS INNES: If we move on please to CIS-000010545, we see a letter here from Dr Pithers to the Care Commission, dated 26 May 2004, and this is follow-up in relation to the relationship between Woodlands and the local police.

If we look in the second paragraph, he says:

'I enclose a copy as requested of the memo of clarification on the use of holding measures. We hope that this will release staff from some of the inhibitions that seem to be leading to watching situations get out of hand whilst avoiding unnecessary and precipitative use of holding.'

It looks as though the Care Commission have asked for this memo to staff.

If we look on to page 3, we see the memo, dated 20 May 2004, and it says in the first sentence:

'It's not in the interests of young people and it will not help us meet their needs if they are allowed to feel that they can do what they like. Apart from anything else, if they repeatedly get out of control, it will lead to the ultimate termination of their placement. Most are at the end of the road in terms of reasonable and humane placement.'

That would seem to reflect a view on where the children who were in Woodlands might go next.

A. There was some reference in another document to some of the children having previously been placed in secure or moving on to secure afterwards, and I wondered if that was a reference in relation to that.

Q. If we go to the second substantive paragraph, they say:

'There seems to be a myth around that physical holding (restraint) or restricting movement in other ways is disapproved or that it will lead to some sort of disciplinary response. As long as the methods used are authorised by your TCI training and are implemented with due care, this will not happen. Even if on a particular occasion an unauthorised hold is used, providing there is no legitimate alternative, it was used non-violently and in good faith, the management also will support it.'

Do you have any comment in relation to that? So that's suggesting that they should be using the holds in accordance with your training, but if you use a non-authorised hold then, in certain circumstances, it would be supported by management?

A. Yeah. So it sort of comes down to foreseeable risk. So what you would expect for each young person is that there's a sort of list of holds that are suitable for use with that young person and there might be a range of reasons why. It might be because of the level of behaviours that they displayed, the size and strength of the child. It might be because of previous sexual experiences. There's a range of factors that you would want to take into account when identifying which holds are suitable. But, in essence, you're trying to predict what situations might arise and what restraints you

might need to use in those situations and staff would be trained accordingly.

But there are a range of levels of restraint. So just because you're trained in TCI or CALM or another model doesn't necessarily mean you're trained in everything. You should be trained in the methods that you need, suitable for the children that you're supporting, otherwise you're trained in things that you aren't using and you'll forget them and not use them properly.

But it might be that there would be instances that occur that you haven't been able to predict, where you might need to use a hold that you haven't been trained to use and essentially, what they're trying to say is, you would apply the same principles. So a principle, for example, would be not holding a child by their joints, because that's what pain-compliance models of restraint use, so the police method of restraint would rely on pain compliance and we wouldn't expect to see that in residential childcare settings.

So you would always hold a child like on their forearm or here (indicating) and -- so you would apply these principles in the use of restraint, even if it wasn't an authorised method, to ensure that the child wasn't sort of unduly negatively experienced as a result

of that.

But if it is justifiable in terms of keeping the child safe, then I would agree that they wouldn't be -- whatever the language it is that they use, the management would support that.

But what you would expect then is a reflection on that and a recognition that staff need additional training around restraint for a particular young person, for example.

Q. You mentioned, when you were talking about holding by a joint, you described that as?

A. Pain compliance.

Q. Pain compliance?

A. Some models of restraint rely on pain compliance and they will force the joints like this (indicating) to basically force people to comply in a prison setting, for example, but pain-compliant restraint hasn't been allowed in residential childcare for -- since the nineties, I think. For a long time anyway.

One of the kind of principles of restraint would be that you don't hold the joints, because that increases the risk of pain or joint damage obviously.

Q. What you were describing there in terms of staff training, so you would have, as you say, the general training, but from what you were saying, it sounded as

though staff would have to be given very specific training and guidance in relation to the individual children that they are assisting and caring for?

A. Essentially, yeah. You sort of have a core manual of training techniques and then there are other, more bespoke methods that might be sort of higher level, more restrictive, so a prone restraint was referred to earlier, so somebody being held face down on the ground. Prone actually used to be quite common, but it isn't these days.

So if a service was going to be using a prone restraint, I would expect that that only be specified for individual children, not that that's used across the board as a kind of go-to technique. That might be the same in relation to other holds. You might have a very small child, for example, who needs a particular hold because of their size. Or a hold to intervene when somebody's putting themselves at risk and you need to move them away from others. So it sort of depends on not just on each situation, but on each young person as well, which hold you would want to employ. But you would want the staff to have an understanding of which holds were suitable for which child.

Q. Can I ask you now, please, to look at CIS-000010569.

This is an inspection report, if we scroll down,

it's an unannounced inspection, dated 3 June 2004. If we look at page 13, if we look down to the bottom of the page, under 'Recommendations', there's still a number of recommendations there in relation to privacy and dignity, welfare of users, which refers to staff support arrangements in respect of challenging behaviour and again, helping staff to gain greater confidence in their use of TCI.

Then issues about complaints procedures. Then if we go on over the page, to page 15, we see that there are requirements both in relation to, I think, fire safety, individual risk assessment, associated staff training, outstanding training in relation to TCI, and requirements in relation to complaints procedures.

It appears that there were still the same ongoing themes in relation to TCI, for example?

A. Yes.

Q. Then we know that this service went into liquidation on 16 July 2004 and if we can look, please, at CIS-000010523. This is a letter, if we scroll down, from Mr HSO, who is the director of the service, to the Care Commission, dated 27 July 2004.

He notes in the first paragraph that the petition for liquidation was approved on 16 July.

He says that he's been advised that as director, he

no longer has any control, but he can still assist the liquidator. He then says this places him in a difficult situation and he's been made redundant, he's not receiving any remuneration, and he says:

'Subject to your advice, I would like to resign as the registered provider if that is possible.'

In the next paragraph:

'I have done my best to keep Woodlands going for many years to the point of using all my personal reserves. However, the tipping point came very suddenly. Had I been able to anticipate it, I would have contacted you some weeks ago.'

So it looks as though perhaps there were some financial issues that came to light suddenly --

A. Mm-hmm.

Q. -- and the owner is asking whether he can resign as the registered provider.

We see the response of the Care Commission at CIS-000010522 and a letter dated 5 August 2004. The Care Commission write, having been in touch with the liquidator:

'My understanding is that you remain a director of the relevant company, although responsibility for the company's finances have passed on as liquidators. I have taken advice regarding your position and I have

to inform you that we are not able to accept your resignation as registered provider in the present circumstances. We do note that the scope of your responsibility is limited.'

So he couldn't step down as the registered provider --

A. Mm-hmm.

Q. -- had to remain there presumably until the service itself was deregistered or closed?

A. Yes, it looks that way, yeah.

Q. I'm going to move away from Woodlands now and I'm going to move to Donaldson's.

If we can look, please, at the summary providing at CIS-000010040.

This is Donaldson's Wester Coates, so we know that Donaldson's was at Wester Coates and then it moved to Linlithgow, so this is relative to the time that it was at Wester Coates, I think.

A. Yes.

Q. If we scroll down to the bottom of the page, we can see that this is for the period 2002 to 2008.

Then if we go to the next page. We see in the summary under 'Inspection' that over the period April 2002 to December 2007, the service was inspected nine times. One of those was a joint inspection with

HMIE; is that right?

A. Mm-hmm.

Q. If we look at the last paragraph on this page, it notes that requirements identified for the service are noted to have been followed up and reported on at subsequent inspection and the service appears to have been responsive to those requirements or recommendations, is that right?

A. Yes.

Q. If we go on over the page, please.

Under the heading 'Notifications', it says there:

'In May 2002, just after the transfer of responsibility for regulation from ELRIS to the Care Commission, a child protection issue was raised by the school. This led to a robust response from the Care Commission.'

Details of that have been provided to the Inquiry.

If I can take you, please, to CIS-000010464, we can see that this is a letter dated 3 December 2003 from the Care Commission to the Scottish Executive Education Department, additional support needs division. It refers to a discussion with the relevant team leader in relation to Donaldson's College.

Would it be normal for the Care Inspectorate to discuss matters with Scottish Government?

A. Our current practice would be that we would brief Scottish Government on areas that we think are relevant. We have got specified criteria, but it might be, for example, things that the media might have an interest in. Incidents that are outwith the scope of what we would consider normal. For example, a young person being hit by a car and being significantly injured would be an incident that would be outwith the scope of kind of normal incidents.

Sometimes enforcement, particularly if it's a high-profile enforcement, not necessarily all enforcements, so we would brief Scottish Government on some of our regulatory activity, yes.

Q. If we go down to 'Background', we can see that on 7 January 2002 a 16-year-old female pupil at the school made an allegation that she had been raped by a fellow pupil. She didn't want anyone to be informed of the matter and the Principal and Head of Care agreed to her wishes, after consulting the relevant guidelines.

Increased supervision of the young man and extended child protection training to all school staff occurred, but then it notes at the end of [redacted], the young man was excluded from the school following complaints about bullying and increasing violent behaviour.

Then, on [redacted] 2002, so after his exclusion from

school, the school received a report from the parents of a 13-year-old pupil that the girl had made allegations that she had been raped in residence by this young person on 4 March 2002.

I think the issue here is that an allegation of rape had been made and the response to that was to supervise the person against whom the allegation had been made and train staff, but not to exclude the person against whom the allegation had been made?

LADY SMITH: Not for that allegation.

MS INNES: Not for that allegation.

But then once he was excluded, it came to light that in the intervening period, there was then another allegation of rape?

A. Yes.

Q. I assume that the timeframe of events would be a matter of concern?

A. Yes. The concern really is that they haven't reported that externally, so they've dealt with it internally but haven't followed procedures in terms of that external reporting, which would have allowed for an investigation and a more robust response hopefully, which may have prevented it from occurring again.

Q. Then if we look down to the final paragraph, it notes there on 2 May:

'The Care Commission was contacted by the school regarding the situation and we met with the school the following day. At this meeting, the Care Commission were told of the allegation from January and that this had now been disclosed to the police during their interviewing of the young person as a named witness in the investigation reported in [redacted].'

As you say, there were concerns about a failure to externally report this incident. It wasn't reported to the police and it wasn't reported to the Care Commission?

A. Or to social work.

Q. Then if we go on over the page, the first paragraph refers to a chronological report that was prepared. Then, in the second half of that first paragraph, it says:

'As you can see from correspondence, the Care Commission had grave concerns about how the child protection incidents had been handled. The response indicates an acceptance of these concerns and a commitment to improved practice.'

And then it then goes on to set out what the Care Commission did when all of this came to light.

For example, the school was able to assure the child protection co-ordinator and the Care Commission officer

that lessons had been learned:

'Since that date, the school has sought the advice of Care Commission staff on a number of pupil-related matters, none of which have required further intervention by the Care Commission.'

That would indicate that the school had now learned from its mistake?

A. Yes, it seems that way.

Q. Under the conclusion it's noted:

'The principal, through her letter of 15 May 2002, and subsequent contacts, has demonstrated that the child protection practices in the school have been reviewed and improved. The Care Commission officer is of the view that in this establishment it is unlikely that such a poor judgment would be made again.'

Then it notes:

'I trust this information will be helpful in your report to the Education Minister.'

It looks as though it was something that had been raised at ministerial level?

A. Yes.

LADY SMITH: Charlotte, what do you infer from that was the nature of the poor judgment that the Care Commission officer was concerned about? What exactly?

A. I think the failure to report and follow child

protection procedures, and I understand that the young person had said that they didn't want anybody to know, but it's sort of day one of child protection training is never promise, you know, a child that you can't tell anyone. So it's quite surprising that that was missed and, you know, the implications of that are potentially huge.

As I say, if that had been dealt with at the time, it might have prevented this same situation from occurring and another child having been impacted by that.

LADY SMITH: Would you expect the advice about or the direction about reporting also to include the need to explain to the child or young person why you have no alternative but to report?

A. That would be something that I would expect would be covered in training for staff. So, I mean, they said that they had, you know, trained all staff, but staff should be really clear on the procedures to follow if a young person discloses something, you know, don't ask leading questions, don't promise, you know, that you're not going to tell anybody. All of these things should be absolutely clear to staff that these are things that you must do and must not do.

LADY SMITH: Because sometimes you may have to tell the

young person what they don't want to hear, such as you can't keep it secret between the two of you.

A. Yes.

LADY SMITH: Yes. And such as assuring them that you are listening, can they explain to you why they're so anxious about it being reported, so that you have then the opportunity to reassure them that you will address their fears, perhaps about the adverse consequences of reporting and so on.

I suppose what I'm getting at is having as full and supportive a conversation with the young person as you can, but never straying from the non-negotiable being that you have to report, would that be right?

A. Absolutely. Yes.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Just for completeness, the incidents referred to are in respect of RBK who was subsequently convicted in respect of these matters.

You have also provided a summary in respect of Donaldson's Linlithgow, which I'm just going to refer to by way of reference. So it's CIS-000010026, but I'm not going to go into the detail of that. We have that summary.

That deals with the time that Donaldson's was at

Linlithgow, so from 2007 up until they cancelled their registration in 2017 as they no longer provide residential care, is that right?

A. Yes.

MS INNES: My Lady, I'm going to move on to another institution after lunch.

LADY SMITH: Right.

As we leave Donaldson's, let us also leave for lunch, but not leaving the building completely, I hope, Charlotte. I would like to see you again at 2 o'clock if that's possible, all right?

A. Of course. Thank you.

LADY SMITH: Thank you.

(12.59 pm)

(The luncheon adjournment)

(1.58 pm)

LADY SMITH: Welcome back, Charlotte, are you ready for us to carry on?

A. Yes, thank you.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

I'm going to turn this afternoon, to start with, to the Royal Blind School and to the summary provided by the Inspectorate at CIS-000010027.

This is the regulatory history from 2002 to 2014 in respect of the Canaan Lane campus. So we've got two different summaries for the Royal Blind School, one for Canaan Lane and one for Craigmillar Park. So we're looking at the Canaan Lane one at the moment.

If we move to page 2 of that, please, we can see that this was registered with ELRIS from 1998 and then obviously moved over to the Care Commission in 2002 and there were registration certificates issued in 2003.

If we look down to below the table, it notes there that there was an issue in 2013/2014 with regard to the issuing of a certificate to reflect the closure of the Craigmillar campus and the full amalgamation of pupils at Canaan Lane for the autumn term in 2014.

Then it goes on to say in the next paragraph:

'It is noted that Canaan Lane could not accommodate all pupils at the point of closure of the Craigmillar campus and in the period between 2014 and 2016, older pupils were housed in two units, at the hostel, previously part of Craigmillar campus and [another building] previously used as a nursery.'

So we can see there the timing in relation to the closure of the Craigmillar campus and the move to the Royal Blind School, simply being at Canaan Lane.

If we look on to the inspection, we can see that it

was inspected 25 times in the relevant period, up to 2014, with four joint inspections with HMIE.

If we go on over the page, we can see the various gradings over that period and, generally, they were very good over that period.

If we can look please to page 4 and, under 'Complaints', it is noted that there were complaints received over the period and at the very end of that paragraph, it says:

'In the course of investigating the complaint of March 2007, the inspectors identified issues around the use of restraint and issued a letter with requirements on 2 April 2007.'

So is it sometimes the case that during the course of an investigation into a complaint, another issue might arise that the Care Inspectorate would then take forward?

A. Yes, that might happen, yes.

Q. We'll come to look at the documents on that in a moment.

But if we can move to the other summary, please, this is at CIS-000010041. This is in respect of Craigmillar Park, it notes this is from 2002 to 2011. So the dates don't seem to fully tie up with what we've just seen about the closure of the Craigmillar campus in 2014, but I don't know if you're able to shed any light

on that or not?

A. I'm not, no, sorry.

Q. I think if we look down to the sixth paragraph on this page, it says the provider cancelled the registration of Craigmillar Park in May 2012 and amalgamated the service with Canaan Lane.

So that seems to be a different time, as I say.

If we look on to page 4 of this summary, under 'Notifications', it says:

'At the point of transfer of responsibility for regulation from ELRIS to the Care Commission, there was an ongoing child protection case. Details of the incidents and correspondence have been provided to the Inquiry.'

Then it goes on to refer to other notifications.

So I would like to look at some of those documents now, particularly in relation to the 2002 issue to begin with.

If we could look, please, at CIS-000010746. We can see this is a letter from the Royal Blind School to the Care Commission, dated 27 February 2003. We can see that this is, if we scroll down a little, in respect of a Tony Callaghan, who was a pupil at the school, who was later convicted in respect of offences.

If we just look down to the bottom of the page we

can see that the letter is from the vice principal, Alison Thomson.

Here, if we look into the body of the letter, it notes that, in the second paragraph:

'DC Gibson of the family protection unit at St Leonard's passed on the information gathered to the Procurator Fiscal ...'

And to other police forces.

And Alison Thomson did not know what was happening with the investigation fully.

But she then goes on to say:

'Mr Tansley, the principal, and I met with Tony and an education and social work personnel from Ayrshire on 16 December. As a result of the meeting, it was agreed that Tony could not return to the Royal Blind School and that a placement should be sought for him in Ayrshire.'

So it looks as though the school are updating the Care Commission to say 'There is this ongoing investigation, in respect of Tony. We have decided that he can't come back to the school'?

A. Mm-hmm.

Q. Would you expect services to provide those sorts of updates?

A. So the way that our current system works is that we have a range of events that we would expect to be notified of

through our eForms system, so this type of situation we would expect an initial notification and then providers can submit updates to that notification, so the information that's in this would be an update to the original notification to say, you know, the investigation's still ongoing but the young person's moved on from the service.

LADY SMITH: Was I right in hearing you say it was through the eForms system, as in electronic form system?

A. Yes, just the online system that we use, so there's a, sort of, provider-facing side to it and then internally, we can see the other side of that system, once the notification's come into us.

LADY SMITH: Thank you.

MS INNES: If we move on, please, to CIS-000010755. This is a file note of a meeting with the Royal Blind School and we can see that there are personnel from the Care Commission at the meeting, together with Alison Thomson, the vice principal, and Martin Henry, who was then child protection co-ordinator for Edinburgh and Lothians. The date of the meeting is 25 April 2003, and it says:

'This was an advisory meeting with the aim of updating the Care Commission with regards to the recent child protection investigation and to look at the Royal Blind School's current policy and procedure in relation

to future child protection concerns.'

So if we look in paragraph 1, we can see that this is the investigation in relation to Tony Callaghan. Would this sort of thing happen now, where the Care Inspectorate are having a meeting with the provider and the local child protection co-ordinator is also at the meeting?

A. We might join a meeting. It would depend on the circumstances, but I can certainly think of examples where we have joined similar meetings where there have been child protection concerns, particularly like this one, it sounds like quite a high-profile concern, and we would have an interest both for our own assurance in terms of knowing how the service is responding to the incident and how they're engaging with external partners in relation to that.

LADY SMITH: Is it also simply to enhance your own learning? This was obviously an unusual set of circumstances and if you, the inspectors, know about the possibility of that set of circumstances arising, it helps you to know what you should be looking for in the future, doesn't it?

A. Yes, absolutely, yes.

MS INNES: Then if we look on through the paragraphs, there are various matters raised by Alison Thomson in terms of

accessing, for example, Sue Hamilton at the City of Edinburgh Education Department for advice and training.

It then goes on at paragraph 4 to note that:

'Martin Henry enquired about child protection training.'

Then, at paragraph 5:

'Alison Thomson confirmed that the school's Child Protection Policy was to be reviewed in line with Edinburgh and Lothian's child protection guidelines, they were advised to look at including how young people are at risk in the community as well as at school and how the school would deal with this. Also the school was advised to look at adapting the Child Protection Policy to take account of specific issues relating to young people with visual impairment.'

So this looks as though it included a discussion about reviewing the policy and what sort of things should be included?

A. Yes.

Q. If we go on to CIS-000010759, we see a letter, I think, from the Care Commission to Alison Thomson dated 30 April 2003. If we scroll down, we can see that this was from Henry Mathias, team leader, who was at the meeting and he was writing to outline the decisions made

at the time, which included, as we've seen, at bullet point 2, you were advised to review the Child Protection Policy.

Then, in the final bullet point:

'It was agreed that the action plan following the annual inspection would be forwarded to the Care Commission.'

So that seems to be a, sort of, separate issue and you talked about action plans following on inspections earlier. Would you expect them as a matter of routine or would you leave the school -- or the service to get on with the action plan and not ask for a copy of it?

A. We would be expected to -- we would expect to be provided with an action plan if there were outstanding actions as a result of the inspection, so if a service was graded very good and there was no requirements or areas for improvement, we wouldn't expect an action plan, although we would always expect a service to have its own development plan in terms of how they were developing the service and taking it forward. And we would have an interest in seeing that during the inspection, but wouldn't request to be provided with a copy of it.

Q. I want to look at something else which came up in your summary, which was the issue of the use of restraint,

which came to light during the investigation of another complaint.

If we can look, please, at CIS-000010984. This is a letter from the Care Inspectorate, dated 2 April 2007, to the Royal Blind School. If we can look down towards the second-last paragraph on this page:

'With regard to the use of restraint, one member of staff commented that at times they had returned one of the young people to their wheelchair and strapped them in to ensure their safety. This was due to staff having to carry out personal care for another young person, which would have left no one to monitor the first child and distract them from climbing the furniture, potentially injuring themselves. The member of staff did not record this occurrence or recognise this as an episode of restraint.'

The writer goes on:

'May I draw your attention to Regulation 4(1)(c) which provides: providers shall ensure that no service user is subject to restraint, unless it is the only practicable means of securing the welfare of that or any other service user and there are no exceptional circumstances.'

Then it says:

'If young people are restrained, as described above,

to meet the needs of the service and not the needs of the individual child, then this would clearly indicate unacceptable practice.'

Then:

'Restraint should not be used as a substitute for comprehensive care and support, compensation for inadequate staffing levels and a device for the convenience of staff.'

So would those points all apply equally today?

A. Absolutely, yes.

Q. Then, below that, requirements were made and, at point 1, a policy on restraint had to be developed to clearly identify to staff the appropriate use of restraint.

Then at 2, there's a requirement in relation to the recording of it, who authorised its use and the rationale behind the use of restraint.

Then the third requirement is staff involved must receive appropriate training.

Again, I assume these three points would apply equally today?

A. Yes. The only additional thing I would say in relation to point 2 would be recording and I would add reporting. So we would expect that to be -- that the family would be informed, that the placing social worker would be

informed and also, these days, that that would be reported to us as well.

Q. I think we understand from material that you provided, that the Royal Blind School followed up on these requirements.

If we move to another document, at CIS-000011026. This is from a later period, so this is in 2011, and it's an email chain so I'll have to work backwards a bit.

If we move to page 6 of this, we see an email, it's from the Care Inspectorate to the Royal Blind School, dated 20 December 2011. The writer says:

'We have had a concern expressed to us regarding inappropriate restraint being used within classrooms, both at Craigmillar and Canaan. The concern is that there are several pupils who were kept in their seats with belts.'

So that sounds similar to the issue that we have just seen from 2007?

A. Yes.

Q. Then the writer says:

'Can you confirm the Care Inspectorate's understanding that both sites work with visually impaired, multiply disabled young people and a number of these youngsters have no or very little mobility. By

necessity, they will require assistance to be seated safely. Some youngsters will remain in their wheelchairs, others will have adapted seats that may involve straps or harnesses.'

Why do you think he would be reflecting that back to the organisation?

A. I think it comes down to the purpose of why the restraints were being used. So, clearly, if somebody requires a restraint to remain seated safely in their wheelchair, that would be an acceptable use of restraint, because it's a risk mitigation in terms of if they're not strapped in, they might fall out of the wheelchair and injure themselves.

But if the restraint is because you're short staffed and you don't have enough people to safely supervise the young people, which is what we saw earlier, then that's an inappropriate use of restraint. So I think that they're trying to unpick that a little bit by making the point that some young people will require assistance to be seated safely.

Q. And then he goes on to say:

'You may feel it is wise to instigate a precautionary investigation to satisfy yourself that no inappropriate restraint is being used.

'If you so choose, it would be greatly appreciated

if you could inform me and Kate Hannah of HMIE of the outcome.'

If we go back to page 5 now, please, towards the bottom of the page, on the same date, we see an email in response from the principal of the Royal Blind School, she says:

'I can confirm the statement you have quoted below is correct.'

So the statement in relation to some children needing to be seated in wheelchairs:

'Many of our pupils require support belts to enable them to be correctly positioned in their wheelchairs or other mobility positioning equipment. In some cases, this is for postural support and in some cases for their safety. We do not restrain pupils for behavioural reasons. However, as the concern has been raised, I will carry out an investigation and inform you of the outcome.'

So she clearly goes on to carry out an investigation. If we could look from the bottom of page 2, first of all, so we can see an email again from the principal of the Royal Blind School, dated 22 December 2011, and this is to the Care Inspectorate.

If we go on over the page, she says in the second paragraph:

'In response to this concern, the deputy headteachers carried out an initial investigation at both campuses.'

They noted that there were three pupils who, although ambulant, sometimes wear a lap belt when seated. Then she says:

'As a response to the investigation, we have commenced a review of policy and procedure relating to positive behaviour support and will communicate this to all staff in due course to ensure that all staff are aware that belts are to be used only for postural support as part of a therapy programme and in cases where a safety risk has been identified and appropriately documented.'

Then she provides further details, I think, in particular to a specific class. So at point 2 she notes that they spoke with a teacher of the class where it appears that belts are being used. If we move to point 4, it says:

'The class have been advised to stop using lap belts immediately and review their day-to-day operations. If it is found that there are situations when a lap belt or other form of restraint is appropriate, then only after discussion and other options being trialed and found to be unsuccessful will a firm plan be considered. If this

is the case then all involved in the care and education of the pupils, including parents, will be involved in the decision.'

That would then be documented. Is this the type of response that you would expect in relation to this issue?

A. Yes, although this relates to a school setting, so we obviously wouldn't have had any remit in that setting, but in terms of their investigation and follow-up response to that, it seems thorough.

Q. Then if we go to the top of page 2, I think we see the final response from the Care Inspectorate at that time, saying that laudably remedial action was immediate. He then goes on to say:

'I think this not only reflects RBS's openness and commitment to reflection upon and improvement in practice, but also indicates the very positive and co-operative relationship that RBS maintains with the Care Inspectorate.

'By responding proactively and quickly to what appeared to be a low-level and unsubstantiated concern, RBS has identified and remedied an area of less than ideal practice.

'This scenario is a very good example of how regulators and providers can work together, in

a proportionate manner, to ensure better outcomes for young people.'

Would you say that is part of the Care Inspectorate's role, to work alongside the provider?

A. I think more broadly in terms of how we engage with the sector, we've done a lot of that in recent years and there are several examples of the work that we've done in relation to restrictive practices referred to in the report that we have engaged with the sector on, thinking about how we can work together to improve children's experiences.

I think in relation to specific providers and services, it's difficult, because we want to encourage that openness and communication, but we can't unknow what we know and so services, when they're open and honest with us, I suppose, risk the implications of that -- you know, telling the regulator about an area of poor practice.

Of course what we want is for services to identify these things and address these things themselves. That's -- that's much better than us having to come in and say, you know, 'This is where you need to improve' and sort of directing services to do that.

But in that openness and honesty, then, you know, they risk, for example, that impacting on, you know,

future scrutiny work or their grades or these types of things, so I think Duncan's summary there is reasonably accurate, yes.

Q. Can we move on, please, to look at Harmeny. If we look at your summary first of all at CIS-000010034.

If we go on to the second page, we can see the registration history and then in 'Inspection history', we see that it was inspected 24 times over the relevant period, with four joint inspections with HMIE.

If we look on to the next page, page 3, in terms of the gradings provided by the Care Commission and Care Inspectorate, generally over the period where these have been graded, they've either been very good or excellent, is that right?

A. Yes.

Q. If I could ask you, please, to look at another document in relation to Harmeny, this is CIS-000010083.

We see that this is a letter to Harmeny dated 3 March 2010 and we see, in the first paragraph, that it says:

'Following the unannounced inspection of Harmeny School in 2010, we agreed to make further investigations into the requirement for night awake staff at Harmeny School to be registered on the register for residential childcare workers held by the SSSC.'

Does the Inspectorate look at whether the staff are registered? Does it check that when it carries out an inspection?

A. We would, as part of our inspection, sample staff on the SSSC register, yes.

LADY SMITH: It looks as though what was happening there was if somebody was employed simply to be on night duty, Harmeny weren't insisting on them having registration.

A. That's my understanding, yes.

LADY SMITH: But they could be called on during the night to do direct work with children of exactly the same sort that a member of the day staff might have to?

A. Yeah, I think their position was that they felt that night staff were more aligned with a, sort of, housekeeping role than a care staff role, and that because they had sleepover staff who would be called upon and that most of their children slept through the night, that they felt on that basis that their night staff weren't required to be registered.

LADY SMITH: Thank you.

MS INNES: If we look down to the paragraph beginning:

'I understand that your position is that the night staff fall into the same category as the housekeeping staff.'

As you've just said, the writer says:

'There is an important distinction between night awake staff and housekeeping staff.'

And at the end of that paragraph:

'The SSSC registers staff according to the job function and the job function of the night awake staff clearly includes a very important aspect of care for very vulnerable children during the night.'

Then, going over the page, we can see that a requirement was imposed in relation to this.

If we can look, please, at SGV-001033705.

This is a letter from Harmeny to the SSSC, dated 22 March 2010. This seems to be in response to the Care Commission's position and the writer refers to that at the beginning of the letter.

He says:

'My understanding of the current Care Commission stance is that they are required to enforce SSSC decisions on eligibility for registration of the workforce and from information provided to you, your conclusion was that our night awake staff needed to register.'

He then says that he's concerned that his position hasn't been completely understood.

If we go on to the next page, please, there's bullet points towards the bottom of the page, so just in the

preamble to the bullet points, the last sentence of that paragraph says that:

'Harmeny management attempted to explain our rationale for not viewing night awake staff as residential childcare workers on two main counts.'

Then it notes:

'Personal care and personal support is a minor and incidental aspect of the role of night awake staff in the context of Harmeny.'

Then, I think, he goes on to say, well, the particular children that are cared for in Harmeny don't really tend to wake up during the night.

Then the next bullet point, which is at the bottom of the page, he says:

'In order to comply with registration conditions, there is a requirement that during a maximum three-year period both the HNC and Level 3 SVQ in health and social care will be achieved by registrants. As employers, we have particular responsibilities to support registrants in the achievement of their awards.'

Going on over the page, he seems to express concern about getting staff with appropriate qualifications to do that role.

Would that make any difference to the position in respect of night awake staff?

A. No, I mean, I appreciate the difficulties with trying to put night staff through training programmes, but that issue wasn't unique to Harmeny. The whole of the sector experienced that when the qualification requirements came into force that, you know, that they were required to make accommodations to people's shift patterns to enable them to gain the necessary qualifications.

Q. Then if we look, please, at CIS-000010107.

This is a call between the Care Commission and the SSSC on 22 March. The person from the SSSC had replied saying that the SSSC had no locus in discussion with Harmeny about whether or not Harmeny's night awake staff should be registered. Why would they say that they had no locus to be involved in this discussion?

A. I don't know.

Q. Would you expect them to be involved in such a discussion?

A. I would have thought so, yes.

Q. In any event, if we look towards the bottom of the second paragraph on this page, we see:

'On the basis of the information the Care Commission have given to the SSSC about Harmeny, they agree that the night awake staff need to be registered and so would other care staff in other similar services where they fulfil the same role.'

As you've just said?

A. Yes.

Q. I think you'll know that that was then actioned by Harmeny?

A. Yes.

Q. Now, I'm going to move on to look at Lendrick Muir or Seamab. Your summary first of all, at CIS-000010035.

We can see, if we go on to the second page of this, the registration history. Essentially, this has been registered throughout the relevant period. If we look to inspections, we can see it was inspected 23 times over the relevant period, with three joint inspections with HMIE carried out in the same period.

It's right at the bottom of the screen.

If we go on over the page, when we see the gradings provided by the Care Commission and Care Inspectorate, we can see that initially the gradings were 'good, 'very good' and 'excellent', but if we look to 21 January 2014, we can see that the grading for quality of care was 'weak'. Then at 6 June 2014, we can see the quality of care, quality of environment, quality of staffing was all graded as adequate?

A. Yes.

Q. So there seems to have been a change from the previous position where the grades were higher.

Then if we go on over the page, to page 4, at 'Complaints'. You note that there were seven complaints received, the majority of these were in 2014. We'll come to some of those in a moment. Then in terms of notifications, you note that, in 2013, the Care Inspectorate received information from the school on the suspension of three members of staff. So, again, that's come through the notification process.

We'll have a look at some of the relevant material. If we can look, please, at CIS-000011298. We can see that this is dated -- it's a note of a telephone call and it was created on 16 September 2013.

If we go down to the body of the text, it says:

'Telephone call to Joanne McCreadie.'

Who we understand, I think, to have been the manager who was registered at the time with the Care Inspectorate?

LADY SMITH: I think it's 'Joanna'.

MS INNES: Joanna, sorry, yes.

LADY SMITH: She's no longer with Seamab, I don't think.

MS INNES: Not currently.

LADY SMITH: If it's the same Joanna McCreadie I'm thinking about, she's with Redress Scotland.

MS INNES: Perhaps.

LADY SMITH: It may be the same person.

MS INNES: She explained the sequence of events relating to the notifications, and then she says:

'During an incident in which a child was held, on Sunday 8th, the child told staff that his wrist had been hurt during the restraint. The staff member involved was moved to another part of the service. Emergency social work were informed but took no immediate action. The child was x-rayed and the wrist was found to be broken.'

Now, given what you have already told us about restraint, I'm assuming that if a child has broken their wrist in the context of a restraint, that would be concerning?

A. It would be concerning, yes. I mean, restraint is -- there are risks involved and children do sometimes get hurt during restraints, which is why it's so important that staff employ particular models and follow particular principles, as we spoke about earlier.

That's not to say that accidents still don't sometimes happen, but the -- I think, in that situation, the important thing is the service's response to that, so obviously the immediate thing is responding to the child's injury, but then, in terms of following up on that, to ensure that best practice was followed or establish whether that was the case or not. Then if

there's any learning from that, if the staff member needs additional training or support or there are other factors that would prevent such a situation happening again.

Q. We can see just in that same -- the first part of the -- this note, it does note that the staff member was suspended as soon as it became clear that a full child protection investigation was going to be carried out, and obviously the Care Inspectorate had also been notified. So these would be the things that you would expect the service to do?

A. Yes. It might not necessarily be the case that there was a practice issue there. It might have been an accident and I've seen that in other services more recently, where a child has been injured and it's been accidental, because children are wriggly and restraints are never straightforward, but you would still expect that investigation to take place to establish what did actually happen and whether that requires further action.

Q. Then in the next section of the note it says:

'In a separate investigation following staff whistleblowing, the Head of Education interviewed all staff. The next staff member about whom there were allegations is a senior practitioner who has been at

Seamab for seven or more years. The allegations were about inappropriate favouritism towards one child; buying fizzy drinks, pizzas et cetera, query grooming. During the investigation, one senior team leader was spoken to on two occasions and said that they had no concerns now or previously.

'Due to that team leader then being on annual leave and paperwork regarding annual appraisal being required, access was gained to her locked filing cabinet, where a file was discovered containing records of concerns raised over a number of years on three members of staff, including the one about whom the whistleblower had concerns. The concerns had been about inappropriate restraint to desexualise a child, staff filming a sex act and subsequently deleting this, and staff raising concerns about boundaries. These had not been investigated or ...'

LADY SMITH: Can we move the page down? That's it, thank you.

MS INNES: Just reading the top of the page, it says:

'... had concerns.'

Going to the second paragraph there:

'The team leader, when questioned, said that they had forgotten about these. They are now also suspended and a full investigation has been started, board have

been informed and await the appointment of an investigating officer.'

So this seems to be another issue that has arisen because of whistleblowing. It appears that one thing has led to another. The team leader said that they had no concerns about this person, but there were concerns in the file that hadn't been taken further and it appears that the relevant staff had been suspended. Again, is that the approach you would expect a service to take?

A. Absolutely, with that range of issues that are identified there or, you know, similar issues, we would expect that they take steps to make sure that children are safeguarded while that investigation takes place, and that might include suspending staff to enable them to undertake that investigation.

Q. Then there's the next couple of paragraphs talking about her keeping the Inspectorate informed of developments. Then the care inspector says:

'I asked whether there were training issues regarding the use of safe holding. They use CPI at Seamab ...'

That sounds like a different method?

A. It is, I can't remember what it stands for.

Q. '... and Joanna McCreadie advised that they will look at

this as part of the investigation. She thinks that the member of staff shows poor practice in other aspects. They have just returned following a disciplinary about not administering medication. Rather than CPI training for the staff team being in question, it may be the member of staff's implementation that is in question.'

So that seems to be her reflection on that incident at that time.

Just bear with me a moment.

That document that we were looking at was dated 16 September 2013 and then I would like to take you to CIS-000011219 on page 5, where we see that this is a notification in respect of something that happened on 17 September 2013.

So a different incident to the one where the child had broken their wrist?

A. Yes.

Q. We see that on the evening of 17 September, the child had said that a member of staff on duty had hurt her arm while walking along the corridor by holding her wrist. No member of staff had witnessed the incident. The senior on site phoned the senior on call. It was agreed to treat it as a child protection concern, as the child had made an allegation, and then it was reported to the out-of-hours social work service.

Then on the morning, there was discussion with the allocated social worker, it says:

'The child had made the allegation the evening before and at the time had been showing challenging behaviour. During the morning, the child had experienced an epileptic seizure (she has a diagnosis of epilepsy), the social worker asked that Seamab staff speak to her again about what she had said and she repeated the same allegation.'

And the social worker was going to come out and see the young person. Then it says:

'The member of staff who is the subject of the allegation has been moved to a different bungalow and care team while this matter is ongoing.'

So, again, this is an issue about restraint and an allegation being made and the service seem to have taken a number of steps in response. Again, are these the steps that you would have expected them to take?

A. So, I wasn't really clear if it was a restraint, 'cause I think it said that her wrist was held so it sounded as though maybe they'd been, like, led down the corridor. But, as I said earlier, I would expect that if you were leading a child you would hold their forearm and not their wrist so that you don't cause any pain or damage to the joints. So there's an issue there.

But in relation to their response to that, I suppose the only bit that might be questionable is moving the member of staff to a different bungalow.

As I said earlier, it comes down to the service's risk assessment of that and what they feel is appropriate, so it might be to suspend the member of staff, it might be to move them on to office duties, it might be to move them to a different house and it depends on a number of factors.

I suppose our role would be to allow the service to take the action that they decide is appropriate and we would respond to that if we felt that it wasn't appropriate in the circumstances.

Q. If we look on to another document, please, CIS-000011456.

Again, if we go to page 5 of this document, this is a notifiable event which occurred on 26 September 2013. It says:

'At the Seamab 25th birthday party, a member of staff was observed to respond to a child by physically removing them from the room by the arm and then speaking to him. The senior manager who observed this believed that it was done in an inappropriate way.

'The senior manager spoke to the person about what had happened. The staff member said that they had been

concerned about how the child was presenting and refusing to have eye contact. The member of staff also said that he had been asked to remove the child by another member of staff.

'Due to the concern about how the staff member handled the issue, an investigation has been started. This is expected to be completed quickly and the SSSC is also being notified of the investigation.'

And the member of staff was told that an investigation had been started.

So this appears to be another issue that's raised in relation to how a child is being physically removed from a room. There may be similarities with the other incidents that we've looked at?

A. Yes.

Q. If the Care Inspectorate spot a pattern with notifications, would that give rise to particular action?

A. It can do, yes. Often we'll make contact with the service and speak to the manager. For example, if we think that their response to incidents hasn't been sufficient or we require further information, so that might be one course of action.

It could be anything from that, through to a visit to the service, bringing forward an inspection or even

resulting in enforcement, depending on the situation.

Q. If we can move on, please, to CIS-000011365.

This is a note of a meeting. And if we look down, it's a meeting held on 9 October 2013, attended by Joanna McCreadie, by a board member of Seamab, and two people from the Care Inspectorate, I think.

Andy Sloan is described as a team manager and Shelagh McDougall as an inspector.

A. Yes.

Q. Then it says:

'The aim of the meeting was for Seamab to give updates on the current situation with staff.'

It looks like there was restructuring going on.

There's reference to whistleblowing at the bottom of the page.

If we go on to the next page, at the top of the page we can see that the Head of Education was appointed to carry out an investigation. This was in relation to the, query, grooming incident?

A. Yes.

Q. It says:

'Most of the staff team confirmed the allegations and during the course of the investigation, it became apparent that the staff member had taken a child off campus with no explanation and made no records of the

event.'

And they were looking to move to a disciplinary proceeding.

They then note that, during the investigation, it became apparent that the team leader had the file with concerns that hadn't been dealt with. Then it says that the school are looking through all records to see whether other patterns will emerge.

Then it goes on to talk about the senior management team putting vision and values in place to share with staff to ensure they've a shared understanding of what's expected, acceptable and unacceptable. Team meetings are compulsory for all staff. They were previously optional, it says, with an exclamation mark.

Would you be expecting regular team meetings to take place on a compulsory basis?

A. Yes. I wouldn't expect the full team to be at every team meeting, 'cause staff will operate on a rotational basis, but you would certainly expect them to attend a number of meetings throughout the course of the year.

Q. Then it says supervision and appraisal has been put in place, which wasn't in place previously. There is a comment by the board member, I think, that it was a staff group of very mixed skills and experience, some of whom would need to make significant progress to reach

a satisfactory level.

Then there's a note that there's going to be a disciplinary hearing in relation to the team leader who had failed to pass on and investigate concerns.

Towards the bottom of the page, there's reference to issues arising from restraints. It is said that a new system of reporting has been introduced, which reports to the head and to the board. Procedures are now in place. There were other discussions about how to manage staff. Some staff weren't happy about it. There was reference to a reminder, essentially, about whistleblowing procedures and grievance processes.

Then it says:

'The school are now looking at other schools in the sector to take ideas on in practice. Shelagh suggested that they look at Harmeny as best example. Some reluctance about this due to ill-feeling re grant-aided status. Advised this was not helpful and look at best example, whether they get a grant or not.'

There appeared to be perhaps tensions about the way in which different schools were being funded?

A. Yes.

Q. Again, this type of meeting in which these issues are being aired, with a board member being there and the head being there, is that something that the Care

Inspectorate would do, where you have got this pattern of concern?

A. Yeah. It's not a common occurrence, but certainly it's something that we would do, where we've got concerns and, as you say, in this type of situation, where there is a pattern and a range of concerns for this service.

Q. Then if we can look, please, at CIS-000011414. We see that this is an inspection report on an unannounced basis on 21 January 2014. So this is after the October 2013 meeting that we've looked at.

If we look at page 3, we can see the weak grading that we saw in your summary in respect of quality of care and support. If we look down to what the service could do better, it refers to child protection procedures, medication, safe holding, recording systems and risk assessments as being particular areas of concern?

A. All quite significant.

Q. If we look on to page 16, under the areas for improvement, if we look down to the paragraph beginning 'Information', so this seems to have been something noted during the inspection:

'Information which was possibly a child protection concern was recorded in a child's daily record, but was not passed on. The team leader in the bungalow hadn't

been informed of it and the Head of Care, who is the child protection co-ordinator, did not know of it. This meant that the service had not been in a position to implement their child protection procedures to follow up the incident.'

And that gave rise to a requirement, so I think that would be the issue that perhaps gave rise to the weak grading in respect of child protection?

A. Yes.

Q. If we look on to page 17, there's the third paragraph on this page:

'A child who had enuresis, particularly at night, did not have an agreed protocol for staff to manage this. It was evident that some staff were sensitive towards his feelings, however we felt that this was not consistent.'

And that gave rise to a recommendation.

Then if we look on to page 18, I think we see the requirements there, including identifying, at number 1, the care needs of the young people and care plans and you've referred already in your evidence to the importance of that.

Then at 2, a requirement in relation to staff having good knowledge of their responsibilities in relation to child protection.

Then at 3, a requirement in relation to risks to wellbeing being clearly identified and known.

So these are amongst the requirements that were imposed on that occasion.

Would you expect that they seem consistent with what was being found at that time?

A. Yeah. You can see how the requirements were reached based on the concerns that we had at that time.

Q. Then if we look at CIS-000011202, it's a letter to Joanna McCreadie dated 14 February 2014, and it says:

'I write to acknowledge receipt of your letter dated 31 January and attached documentation. In response to the issues you raised at feedback and dissatisfaction with the proposed grades, I arranged for another team manager to review the evidence gathered during the inspection.'

And her feedback was that, 'We had been generous with the grades', referring to guidance on what constitutes a weak grade. They decided not to reduce the grades further, but they weren't making any change, I think, to the weak grading that they had put in the report.

Is it common for services to challenge gradings that are given in a report?

A. It's become increasingly common in recent years, yes.

Q. Do you know why that is?
A. I think partly because it affects their business, if they're operating the service as a business, it impacts on whether or not they can be on things like the Scotland Excel framework, because they have to have a certain level of grading and that then impacts on the referrals that will be made to the service and whether or not they can admit children in the future. So that's always a concern for providers but, more broadly, we get a significant challenge in relation to the response of our inspection reports.

So we have an error response system, where providers should use that to inform us of factual inaccuracies in the report, but what we're finding is 30, 40-page long responses, detailing why our inspection report is wrong, which takes a significant amount of resource for us to go through and respond to each point with the support of the team leader, as this response highlights, as well so that we're not just relying on the inspector to do that.

So that -- that causes a huge implication on resources for us and doesn't often result in a change of grading for the service.

MS INNES: My Lady, I'm staying with Seamab but I'm going to move to 2014, so perhaps it would be --

LADY SMITH: I think we should take a short break.

Charlotte, the good news, and I didn't trail this earlier, is I normally take a break in the middle of the afternoon, a short break just about this point. Would that work for you?

A. Of course, yeah.

LADY SMITH: Good. Let's do that.

(2.59 pm)

(A short break)

(3.10 pm)

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

A. Yes, thank you.

LADY SMITH: Thank you.

Ms Innes.

MS INNES: Thank you, my Lady.

Staying with Seamab and moving to CIS-000011246. This is a record which was created on 3 April 2014 and it notes that it's a telephone call with an Alison Young, who's a social worker. It says:

'Telephone call from Alison Young. After our telephone conversation yesterday, she visited a young person. He has given Alison a very clear account of how he was locked out of the bungalow. He had tried to get back in. It was evening and still daylight, but the door was locked. He stated that the children were

having their dinner but staff closed the curtains so he couldn't see in. He went to Whitewisp to find a member of staff. He says he was crying and upset, he also talked about being hurt when he was being restrained and that he had been scratched last week. Alison asked if he had any scratches and when he showed her his arm, she saw fingertip bruising, which he says is as a result of restraint, which hurt.'

Then, in the next paragraph, she says she is discussing the situation with the Child Protection Unit and it is likely that they will investigate:

'I advised that if they are going to carry out an investigation, we would probably allow this to happen before we conduct any complaint investigation so we do not muddy the water.

'Alison is becoming more concerned that the service is not consistently meeting the child's needs.'

And then, at the top of the next page, it talks about his behaviour escalating and staff being unable to identify triggers and take proactive action to de-escalate the situation:

'Staff are phoning the social worker regularly for advice on how to manage him and she is not confident that they have the skills to provide appropriate care and apply boundaries consistently.'

Then in the final paragraph it says:

'This situation demonstrates increasing concern about how the service is.'

This is a report directly to the Care Inspectorate from a social worker. So the type of thing that you said you were trying to encourage, that if a social worker had a concern, that could be reported directly to you?

A. Yes.

Q. If we go on to CIS-000011214. We see that there's a further telephone call from Alison Young, who is a social worker from East Dunbartonshire, it says in this record, and it had been decided that the young person was not going to be returning to Seamab and the local authority had taken the view that they weren't confident that it was meeting the child's needs. It says they have assessed staff approach to be reactive, inconsistent and punitive:

'Alison described staff placing the young person in his room and holding onto the door to keep it shut so he could not get out. The young person is a complex child, but the school is unable to meet his needs.'

Then there's a further note that the social worker advised that she had been in contact with, I think, Perth and Kinross, who appear to have similar concerns

in relation to a young person from that area residing in Seamab. It looks like the care inspector then went to follow that up. She tried to contact the named social worker at Perth and Kinross.

Is that something that an inspector would do, if given this sort of information?

A. Yes, I think that's a team manager, Alison Jamieson, who's made that recording but, yes, if we were pointed towards something that might give us evidence, then we would have an interest in receiving that information.

Q. If we follow this through to CIS-000011423 --

LADY SMITH: That sounds as though there was an existing background of Alison knowing that Perth and Kinross already had some concerns about their children who were in Seamab, so she felt they ought to know what the current situation was and then you got to know.

A. Yes.

LADY SMITH: Which sounds like joined-up working.

MS INNES: If we follow this through to CIS-000011423, we see that this is a note of a telephone call to South Lanarkshire by Alison Jamieson on 9 April 2014, where she says that she contacted the Perth and Kinross emergency duty team, who confirmed that they had passed the concern in relation to the child with bruising to South Lanarkshire Council and that they have implemented

their child protection procedures, and she's given the details of the social worker.

She then gets some further information and she says that she is following up because of concerns that the Care Inspectorate has in relation to Seamab. It explains some of the findings of her recent inspection and recent situation with another child. Janet, who I think is a fieldwork manager from South Lanarkshire Council, was very concerned about this, given the recent contact and some concerns they had in relation to the young person for whom they were responsible.

She referred to the young person sustaining an injury to his eye while being held onto when attacking a staff member and a door caught him in the eye. He was admitted to hospital.

In the second bullet point, the child alleged that he had been locked out in the pouring rain. His account couldn't be corroborated.

Then if we go on over the page, at point 3, the young person complained that he was being held by his wrists and staff were hurting him. He states that while being restrained, which happened fairly frequently, or regularly, social work describe him as a violent young man who needs skilled assistance in managing this. He had previously assaulted a member of staff at Seamab to

the extent that they needed hospitalisation and stitching.

Then in the next paragraph, it says that the young person's social worker visited Seamab recently and had concerns about how staff were managing his behaviour:

'She asked to see his room. My impression from the conversation is that she insisted on this and found that the young person had written "help me" numerous times on his bedroom wall. This had not been reported to the social worker and this was very concerning to the social worker.'

Then as a result of that, South Lanarkshire had held a child protection meeting:

'Joanna McCreadie attended and stated that there were issues about safe holding and she witnessed some approaches used by staff which were over the top. She stated that there was a need for staff training and she would investigate.'

Then in the final paragraph we see:

'These issues are adding to a growing picture of concern in relation to the quality of care and a number of themes are emerging in relation to restraint, control and children being locked out of bungalows. I will arrange a meeting with two local authorities involved and the police. We need to plan an inspection of the

service.'

So it appears from this that it's almost a proactive contact with South Lanarkshire, so it looks as though that information hadn't come to light directly to the Care Inspectorate, that they had got this information via the East Dunbartonshire social worker. Then they had gone to South Lanarkshire and they got this further information about this other child and, as a result of that, they were going to take further action.

A. Yes.

Q. Is that again what would you expect in terms of this process?

A. Yes. A lot of the time, services for children and young people will accommodate children from a variety of different placing authorities, from across Scotland, or even outwith Scotland, and so when we find ourselves in a position where we have concerns about a service, that can require quite a lot of communication with the various placing authorities to make sure that they are kept informed and that social workers are able to undertake their own assurance or to take action if they feel that the child that they've placed there isn't safe or suitably placed, if they want to remove them from the service, which they sometimes do.

Q. Now can we look, please, at CIS-000011199, which is the

inspection report that was then carried out, an unannounced inspection on 6 June 2014. And I think the visits were carried out in April 2014.

If we go on to page 3, under the grading, we see the adequate grades that we noted in your summary.

At the bottom of the page, one of the things that the service could do better, final note there is that:

'Training in further specialist areas of work should be undertaken by staff to meet the diverse needs of the children who live there.'

Then at the top of the next page, it says:

'The service needs to review the significant incidence of restraint and absconding and take appropriate action to minimise the frequency of these events.'

Again, do you know if the service addressed these issues that were raised in this report?

A. I don't, no.

Q. I think we do have other information which suggests that they provided various action plans and carried out an audit of restraint incidents and absconding to try to ascertain any themes at that time.

Just finally on Seamab, if I can ask you please to look at CIS-000011331.

This is an issue in relation to a complaint and the

letter is dated 5 August 2014. This is from the Care Inspectorate to Seamab. And if we look down to the bottom of the page, it says:

'On 28 March 2014, the Care Inspectorate received a complaint about your service that stated that a named child was inappropriately locked out of their home.'

If we look down to the conclusion:

'The complainant was concerned that staff supporting the child had deliberately locked the child out of their home. The complainant said they'd escorted the child back to their home and found the doors to be locked. They then contacted the bungalow and allowed the child back in.'

If we go on over the page, to page 3, just above the number 4 it says:

'Based on the evidence, the complaint is upheld.'

And in the paragraph just above that, yes:

'In reviewing the evidence, we conclude that the child was inappropriately locked out of their home. We conclude that this was done to manage the child's disruptive behaviour which was impacting on other children. We conclude that this was an inappropriate behaviour management practice as it was reactive and failed to take account of the child's health and welfare. We also conclude that an incident report

should have been completed as the child was distressed and there was conflicting information about the event.'

So obviously, there's the issue of the child being locked out, but there's also the issue of reporting and am I right in understanding that what's meant here is even if there's conflicting information about the event on one approach, this has happened deliberately, and therefore is inappropriate and needs to be reported. So the service needs to look at it on that analysis, even if somebody else disagrees with that?

A. Yeah. It should still be recorded and reported, regardless of the views about whether or not it should have happened. It still happened.

Q. I'm going to move on from Lendrick Muir to Starley Hall. If we can look, please, at your summary, which is CIS-000010031.

We can see that this is a service that was registered throughout the relevant period.

If we look on to page 2, under 'Inspection', we can see that the service was inspected 26 times over the relevant period, with seven joint inspections with HMIE over the same period.

LADY SMITH: So that's 26 times in 12 years?

MS INNES: Yes.

LADY SMITH: Yes.

MS INNES: If we look at page 3, we can see the grading and we can see in respect of the report of 9 June 2009, there is a weak grading in respect of quality of environment, but other than that, the grading is generally very good or excellent.

A. Yes.

Q. Where it's been assessed.

A. Yeah.

Q. If we look on to page 4, please, under 'Complaints', it notes that there were five complaints.

There was a complaint in 2009, which led to the dismissal of a member staff and a complaint in 2013 led to a review of the grades awarded at the previous inspection.

So we'll have a look at both of those issues, if that's okay.

A. Okay.

Q. If we can look please at CIS-000011055.

This is a complaint, the letter to the school is dated 29 May 2009. The details of the complaint are that a staff member was alleged to have had an inappropriate relationship with the child of the complainer and, following a police investigation, he was back at work. She believed that he was not suitable to work with children and young people. The way in which

this was dealt with under 'Method of Investigation' is that there were visits to the service, a telephone conversation with the complainant and liaison with the police.

If we go on over the page, to page 2, it refers under 'Conclusion' to the complaint itself.

It appears in the middle of that paragraph, it says:

'On receipt of further information from the police and a further visit to the service on 8 May 2009 by a Care Commission officer to explain the police findings, the director decided to hold a disciplinary hearing at Starley Hall. The complainer was suspended for eight months during the police investigation, but had been reinstated when the service believed that the police investigation was closed and that there were to be no further proceedings. Documentation received from the police confirmed that no proceedings were being taken at that time. It had come to light, however, that the individual would not get a clear disclosure and would not be eligible for registration with the SSSC.'

Then there was a disciplinary hearing. He didn't attend and he was dismissed.

So here the issue seems to be that the service were given information by the police that they weren't going to proceed further and then the staff member was

reinstated, but the Care Inspectorate's view was that other steps should have been taken.

Again, is that what you would expect, that you would expect further steps to be taken?

A. Yes, so we would expect the police to conduct their investigations first, but just because there's no evidence of criminality or charges to be brought, doesn't mean that there isn't learning in terms of the staff member's practice. So once the police investigation is concluded, our expectation would be that the service would undertake their own investigation and reach their own conclusions about suitable steps following that.

So it might be to dismiss the person. It might be to offer them a written warning. It might be to decide they need additional supervision and training, depending on what the outcome of that investigation is, but we would expect that they undertake that.

Q. If we look on, please, to CIS-000011107, we see a letter from Starley Hall to the Care Commission, dated 4 August 2009, and this is asking for reconsideration of the grading in the 2009 inspection.

I think this is to do with the weak grading that we saw in your summary. The understanding is that this arose from the issue that we have just looked at.

If we go on to page 2, it is said that the whole tenor of the inspection report doesn't indicate that the service merits a weak grade.

Then if we go on to the next paragraph, it says:

'We are very clear that it is appropriate to mark this issue with a lower grading. We do not understand the insistence that this merits a weak grade. Prior to the inspection, we had evaluated the situation and put steps in place so that we could learn from this experience. These were discussed in advance of the inspection with the Care Commission. We had already taken action in our service before inspection. I revisit this point later in the letter.'

And essentially, so it goes on. The author is saying that they acted promptly when it was brought to their attention, but ultimately I don't think the grading was changed, it seems to have remained at 'weak'.

And is this another example of somebody challenging a grading?

A. Yeah. Clearly, the author of the letter set out their view about why they think the grading is unfair and the fact that they believe that they responded appropriately and that it wasn't their fault that this had occurred, but obviously our view was different.

Q. Because I suppose the point being made is: well, we've sorted it out now, you don't need to censure us in some way by grading us in this way?
A. Yeah, but the concern is that it happened in the first place and that they needed a prompt to take that action, when we would expect that they would have taken that action without us directing them to do so. Whether or not harm has occurred as a result of that is irrespective really, because there is a potential for harm to occur as a result of that.
Q. Then if we can look, please, at CIS-000011053. We see a letter here to the Care Commission. If we look down, this is about the 'Disqualified from Working with Children List' and this is in respect of the same staff member and it says that:

'Starley Hall School has referred the staff member to the Disqualified from Working with Children List on the basis of allegations that he had formed a sexual relationship with a child in his care. The 14-year-old, at the time, female resident arrived in Starley Hall in [redacted] 2007.'

It notes that he was working there at the time.

Then if we look down to the final paragraph, it says:

'As required by legislation, this letter gives

notice in accordance with paragraph 6 ... that the Care Commission is invited to provide any further information which it considers relates to this reference.'

By a specific date.

Would the Care Inspectorate still get requests in relation to this for comments in relation to an application or information that would tend to suggest that somebody should be put on what was then called the 'Disqualified from Working with Children List'?

A. I'm not aware that we've been asked for our view or information, but we do sometimes get correspondence to advise us of action in relation to whatever that list is called now.

LADY SMITH: I don't know. The 'barred list', I suppose you could refer to it as.

I suppose Disclosure Scotland aren't to know when you're next going to be looking at that place and it may be very useful for you to be aware if, as it happened, you were shortly going to be inspecting it, because you might not otherwise know.

A. Yes. And sometimes we are aware, because the service has notified us of an incident, and it's helpful to get that correlation from another agency, because sometimes services will say, 'We've reported this and there's no further action' and to have that assurance from another

external partner is helpful.

LADY SMITH: You might also be in a position to pick up that that person has gone to another provider --

A. Yes, we do get that.

LADY SMITH: -- having been passed on by the provider that was very glad to get rid of them and it may be possible for you to find out how that came about and did the new provider know about these proceedings and the barring.

A. Yes. That happens particularly with managers as well, we see managers popping up in different services.

LADY SMITH: Thank you.

MS INNES: We know from the material that you have provided that that was responded to with an account of the Care Commission's involvement but if we can move, please, to SGV-001032160.

If we look at the bottom of this first page, we see an email from Kate Hannah to various people on 1 October 2009. So we have been looking at material from July and August 2009, but if we go on to the next page, it says there:

'I have been advised by my Care Commission colleague ... that a serious child protection issue has arisen in relation to Starley Hall, where a member of staff is being investigated for sexual abuse of a young girl. Morag informs me that the service did not follow its

safe recruitment policy and was to some extent aware of the risks associated with the employee concerned. More detailed information will follow shortly.

'I note that Starley Hall is due an integrated inspection in January to March 2010 and was wondering if we might consider bringing that forward.'

This, we can see, is from the lead inspector in relation to alternative provision at HMIE.

So there seems to be a suggestion that a joint inspection should be brought forward and if we move back to the first page, the response to that from the Registrar of Independent Schools indicates that it sounds quite serious and sees an inspection ASAP as a good idea:

'Presumably you can probe these issues during an inspection in some depth, having been made aware of this.'

This appears to have been a further suggestion of follow-up on a joint basis with HMIE?

A. Yes.

Q. We know, again from the material that you have provided, that more inspections took place thereafter.

I'm going to go back to your main report and that's at CIS-000010042.

If we can look, please, at page 16, where you talk

about actions to further strengthen safeguarding and in paragraph 5.1.1, you talk about, and we know from previous evidence, that there's been a move from inputs and processes to outcomes and you refer to the introduction of a new singular key question, 'Key Question 7, specific to service type'.

A. Yes.

Q. Can you explain what you mean by that in relation to the provision that we're looking at here?

A. Okay. So we have -- we regulate services based on the registration categories set out in schedule 12 of the Public Services Reform Act and our quality frameworks, to some degree, reflect those service types, so we have a quality framework for care homes and special residential schools, because we see those two service types as being very similar in the way that they operate. We have a separate quality framework for secure accommodation services, because, although they are similar in some respects to a care home, there are additional implications due to the nature of it being a secure service. Then we have a separate quality framework for mainstream schools, because they operate in quite a different way.

And then we have other quality frameworks, so the quality frameworks set out a range of key questions that

are essentially our inspection framework.

They've been implemented since, I think, about 2022 onwards, on a sort of -- no, it must have been earlier than that, if we brought Key Question 7 in in 2022, maybe it was 2020, on a staged basis, so care homes was first and then by service type we've sort of rolled them out.

As we were coming out of the pandemic, we were thinking about ways in which we engage with services and how we move forward with our methodology, thinking about the learning from The Promise as well, which really called for us to focus on listening to young people and learning from their experiences.

And partly a result of that and partly as a result of our need to be able to visit as many services as possible, bearing in mind that we hadn't visited a lot of services during the course of the pandemic, we developed Key Question 7, so the Key Question 7s that we have in place align with the existing quality frameworks.

So we have a Key Question 7 for care homes and special residential schools and for mainstream schools and one for secure accommodation services.

Q. In terms of the question itself, am I right in saying that it is: 'How well do we support children and young

people's rights and wellbeing?'?

A. Yes.

Q. That's the sort of overarching question that the service is asking itself and that the Care Inspectorate is asking of the service?

A. Yes, so the way that our quality frameworks are designed is for services to use them as a self-evaluation tool. So the questions are worded in that way, but we also use them as our inspection methodology, as I said.

Q. Could I move to page 20 and paragraph 5.3.3. This is where you are talking about team development and you have already told us about training and suchlike specific to this area, but you say:

'In 2024, we established an internal group for inspectors of residential special schools to meet together and reflect on practice with the aim of sharing learning and enhancing consistency.'

Why did you do that?

A. So a couple of reasons.

One is that one of the themes, I think, that has stood out for me in services that we've had real concerns about over the last few years has been that they tend to be services that -- it might be quite a small provider, but they tend to operate in a silo and aren't connected in with the wider sector and aren't

aware of practice that is happening in the wider sector.

And that, in itself, isn't an indication of poor practice, it's just been a theme that we have seen in some of the services that we've had real concerns about. So some of the work that we have been doing with the sector has been to try and connect services into each other and do some of that signposting and we've undertaken a range of pieces of work to, sort of, enhance that, I suppose, because, as I said earlier, we don't want it to just be the regulator saying: 'This is what you have to do'.

If services are connected in and they're learning from each other and thinking, 'This is how we can improve and this is how we can develop', that's kind of what we want to see services doing rather than waiting for us to show up and tell them what they need to be doing.

So there's that aspect of it. But thinking about the same idea, but sort of at inspector level.

And then, alongside that, what we've had in place for a number of years is, in the teams that I oversee, we've got quite a wide range of service types. So, as I said, we've got care homes, we've got special residential schools, we've got secure, we've got mainstream schools, fostering and adoption services,

we've got some support and housing support services as well. What we have tried to do is allocate inspectors based on their previous experience and their specialism, so we have a small group of inspectors that will inspect secure accommodation services, we've got a small group of inspectors that will inspect fostering and adoption services, and these inspectors will generally come to us with some sort of background that means that they have a particular experience that we think makes them a good fit to inspect that service type.

And so we wanted to adopt a similar approach for residential special schools, again with that aim of trying to develop inspectors' expertise in this particular area of practice.

LADY SMITH: How many inspectors do you have now then allocated to residential special schools?

A. I couldn't say off the top of my head.

LADY SMITH: Do you have any sort of feel?

A. So we've got -- at the moment, we've got 24 full-time equivalent inspectors in the children and young people teams, but the actual number of inspectors is slightly higher, because we've got a number of people who are part-time. I would say maybe around ten of those inspect residential special schools, but that number might be slightly higher or lower.

LADY SMITH: Okay, thank you.

MS INNES: If we move on to page 21 of the report, and to a couple of issues that you mention in relation to suggested policy and legislative changes.

You say at paragraph 5.5.1:

'Scottish Government are currently leading on a review of section 12 of the Public Service Reform (Scotland) Act 2010.'

You refer to a review of the section 12 definitions, which you say might be of benefit to children in the settings that we are looking at.

If we can look please on to page 24, we see the schedule 12 definitions. You mentioned this much earlier in your evidence today in terms of the schedule 12 definitions that you work with, where we see, for example, a care home service and a school care accommodation service.

I understand that some work is going on perhaps to review that?

A. Yes. So these definitions are under review at the moment and we've got representation on that group that's being led by Scottish Government, as I understand it. I've mentioned -- several times today, I've used the term 'special residential schools', which isn't a term that you'll see there because it's a term that we use.

So these services are registered as school care accommodation services and then we have created a split, so school care accommodation services are either mainstream boarding schools or special residential schools, but that isn't reflected in the current legislation. That's terminology that we've introduced to reflect the fact that actually, although they're both registered as school care accommodation services, they operate in very different ways.

Q. What difference do you think changing the definition in the legislation would make?

A. It might make it -- it might make it clearer about what services are registered to provide. It could have an impact on the methodology or the aims and objectives of services. I suppose it would depend, but I think the key thing would be clarity in terms of what services are registered to provide.

LADY SMITH: We can also add to your list of mainstream boarding and special residential schools something, I think did we mention earlier, the provision of hostels --

A. School hostels. Sorry, I should have said, they're under that category.

LADY SMITH: Which are neither the boarding school nor the special residential school --

A. There's very small number of those.
LADY SMITH: -- but they are residential accommodation related to the provision of schooling.
A. You're right, yes.
LADY SMITH: Thank you.
MS INNES: Then back to page 22, there you note that restraint and restrictive practices, you have noted elsewhere in the report that sometimes this can be quite prevalent in such settings. I think we have probably seen that in the evidence we have looked at.

You say:

'There is a need for clearer guidance aligning the residential and educational components of these services. We understand that the sector finds the variation in definitions and recording and reporting thresholds and routes confusing.'

Then you note that you have responded to the Scottish Government's physical intervention in schools guidance consultation and met with key stakeholders in relation to the issue.

Can you just explain a little of what your involvement is in relation to this area?
A. Of course.

So the residential childcare sector is still operating to the Holding Safely guidance, which came out

in 2005, I think, so it's quite old guidance now when we're talking about the area of restrictive practice, which has developed quite a lot in recent years.

Last year, I think around October, the updated guidance for education settings was published. So we have services who are providing care and education and even where services aren't providing care and education, children who are moving between care and education settings quite frequently and, at the moment, with one set of guidance for care settings and another set of guidance for education settings and the two sets of guidance don't say the same thing, which I think is confusing.

We are also -- we're using a set of definitions that we agreed with the Scottish physical restraint action group in I think 2020/2021, off the top of my head, and the schools guidance is working to a different set of definitions.

If a restraint or restrictive practice occurs in a care setting, the service is expected to report that -- obviously record it and report it internally and notify appropriate people in relation to the child, but also to report that externally to us. But if the same situation happens in an education setting, there is no external reporting mechanism and that's something that

the residential childcare sector have been quite concerned about, because they're used to notifying us and they feel that they want to tell somebody.

So we get notifications sometimes about restraints that have happened in education settings that we cannot act upon because we don't have a remit in education settings.

There has been a particular concern around restrictive practices that happen in the education settings of secure accommodation services, because of the particular risks for children accommodated in those settings. As a result of that, we've agreed, as an interim measure, for secure accommodation services to notify us of all incidents of restraint and restrictive practice, whether they happen in care or education, and we will pass those that happen in education on to Education Scotland for them to review, provide that external assurance. But, as I say, that's an interim measure and not something that we're in a position to do for the school care accommodation sector more widely.

But we recognise that there needs to be a, kind of, longer-term solution, because the current situation isn't satisfactory.

MS INNES: Thank you.

I have no more questions for you, Charlotte.

LADY SMITH: Charlotte, nor do I, but I do want to thank you for bearing with us for a long day and allowing us to probe deeply into not just what's in the reports here, but your knowledge and experience. Thank you so much for your thoughtful and helpful evidence. It's been really good to have you here and to be able to ask you the questions we have done. I'm very grateful to you.

Now you're free to go. Draw breath and relax for the rest of today. But you go very much with my thanks.

A. Thank you.

(The witness withdrew)

LADY SMITH: And it's not even 4 o'clock, Ms Innes.

I don't have to ask you what the plan is for tomorrow or even for Tuesday. Would you like to just, for the record, remind anybody who is listening of the dates when we will next be starting hearings?

MS INNES: We'll restart hearings a week on Tuesday, 27 May, at which time we will hear evidence from Education Scotland.

LADY SMITH: Yes. Thank you very much.

I wish everybody who is listening who is not here something of a break between now and then and a good weekend when it comes.

Thank you.

(4.00 pm)

(The Inquiry adjourned until 10.00 am on Tuesday, 27 May 2025)

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