



GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

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Uncompassionate Regulation

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February 2024 - No. 287

Regulators are increasingly moving towards “compassionate regulation”. [These initiatives](#) sometimes follow instances of self-harm by registrants facing complaints, investigation, and discipline.

A recent [Coroner’s Inquest report](#) in the United Kingdom has highlighted the need to apply compassionate regulation principles to inspections. While the concepts sometimes overlap, true inspections tend to be different from misconduct processes and quality assurance assessments.

Unlike misconduct processes, inspections and quality assurance assessments are often initiated in the absence of a specific concern. They are typically conducted pursuant to a schedule or even randomly. Sometimes their frequency is influenced by risk data.

However, unlike quality assurance assessments, inspections are often compliance-driven rather than a collaborative, confidential, continuous improvement process.

Inspections generally apply detailed, and often fairly objective, criteria to assess whether a registrant or facility is compliant with specific requirements. The result is a report and, often, a score, along with notification of any corrective steps that must be completed. Increasingly, regulators are expected to publicly post the results of inspections on their website. Regulators sometimes also require registrants and facilities to post a copy of the report in their work premises.

In the UK, the Office for Standards in Education, Children’s Services and Skills (Ofsted) conducts inspections of programs that provide education and skills services, such as through schools, to children. Recently a Coroner issued a report on the death by suicide of a school principal, Ruth Perry, following an Ofsted inspection. A summary of the tragic facts reads as follows:

This was the first Ofsted inspection that Caversham Primary School (‘CPS’) had had for 13 years. There was previously a policy which meant

that schools which had been rated outstanding were not inspected in line with usual timescales....

CPS underwent an Ofsted inspection on the 15th and 16th of November 2022, after receiving a phone call to notify them of this at 1pm on 14th November 2022. Ruth's mental health deteriorated significantly during and after the inspection. She displayed suicidal ideation and planning a few days after the inspection. She sought mental health support, but felt unable to discuss the likely outcome of the inspection in any detail. Ruth had no relevant past mental health history. The records and evidence set out very clearly what the cause of her mental health deterioration was. She took her own life on 8th January 2023.

The Coroner concluded it was "likely that the Ofsted inspection contributed more than minimally to Ruth Perry's mental health deterioration and death."

The Coroner expressed the following concerns about the inspection process:

1. The score of "inadequate" applied, without differentiation, to schools with easily remedial safeguarding concerns (which was the case for CPS) and to a school that was "dreadful in all respects".
2. Parts of the inspection "were conducted in a manner which lacked fairness, respect and sensitivity."
3. There was also no "clear path to raise concerns during an inspection if these cannot be resolved directly with the lead inspector."
4. "There was no written policy, regarding management of school leader anxiety during inspections." Nor was there training of inspectors on this concern.

5. Ofsted's policies did not provide for pausing an inspection "for reason of school leader distress."
6. The Ofsted confidentiality requirements were interpreted by Ruth Perry as preventing her from obtaining the support she needed.
7. In terms of publicly posting inspection outcomes, "Transparency and ease of message to parents is not currently weighed against teacher welfare."
8. The delay in finalizing the report, and its publication, aggravated the situation.
9. Ofsted did not have a mechanism for reviewing and learning from inspection challenges.
10. The municipality overseeing the school provided insufficient support to Ruth Perry.

The Coroner stated that both Ofsted and the municipality should take action "to prevent future deaths".

Ofsted [announced](#) that it would pause future inspections until it implemented a comprehensive and ongoing training program for inspectors.

The Coroner's observations and recommendations tie in closely with compassionate regulation initiatives associated with complaints, investigations, and discipline processes. These include improved and less legalistic communications (especially at the beginning and at the end of the process), training to recognize and respond to wellness concerns, having specialized staff available to intervene when wellness concerns arise, offering support services to registrants, and improved timeliness.

Some of the recommendations are unique including those relating to the wording and publication of the outcomes and not imposing confidentiality expectations that prevent a registrant from obtaining support.

In evaluating these recommendations, regulators, generally, must balance competing considerations. Take, for example, the suggestion that the regulator should consider the circumstances of the registrant in any publication of results. While this has value where the registrant is experiencing distress, regulators are legitimately wary of “negotiating” the content of publication with registrants. Experience has taught that such discussions can be protracted and difficult. Consensus is sometimes impossible to achieve. Further, members of the public might perceive that they are not receiving the “straight goods”. For that reason, some regulators refuse to “bargain” on the wording of publication.

Of course, even the issue of registrant input on the wording of the publication is not an all or nothing proposition. Regulators could provide one opportunity to registrants to make submissions on the content of the publication, while keeping the final decision with the regulator.

The Coroner did not specifically address the tricky issue of how inspection results are communicated. This is not surprising as that issue may be beyond the expertise of most Coroners. Having the inspector provide information about the outcome right at the end of the inspection has the advantage of immediacy. Minor issues can be explained verbally, in the form of informal and constructive feedback and questions can be

answered. This might be a suitable approach where any deficiencies are relatively minor and the criteria to be met are relatively objective.

On the other hand, there are several disadvantages to the inspector providing the results immediately. The manner and content of communication would likely not be consistent across inspectors. There would be no verification and clarification of results by an independent person or committee beforehand to reduce subjectivity and promote consistency across inspections. The interaction could become confrontational. Non-inspection information, from the regulators’ files would generally not be considered (and could not be if it was withheld from the inspector with the aim of enhancing their objectivity). An opportunity for considered submissions by the registrant after the results were already provided could seem like the outcome has already been prejudged.

For these latter reasons, it might be preferable not to communicate preliminary results immediately, at least where there are more serious concerns.

This tragic incident demonstrates that compassionate regulation should not be limited to the complaints, investigation, and discipline process.

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