1 Tuesday, 28 July 2020
2 (10.30 am)
3 THE CHAIR: Good morning, everyone, and welcome to Day 17 of
4 this public hearing. Ms Brown?
5 MS BROWN: Thank you. We will be calling Ms Adcock, if she
6 could be sworn, please.
7 MS CAROLYN MARY ADCOCK (sworn)
8 Examination by MS BROWN
9 MS BROWN: Could you please give your name and your current
10 role, please?
11 **A. My name is Carolyn Mary Adcock, and I'm a senior**
12 **Her Majesty's Inspector with Ofsted.**
13 Q. You provided to the inquiry a witness statement dated
14 22 May 2020, and is that true, to the best of your
15 knowledge and belief?
16 **A. It is, yes.**
17 Q. I think, as well as your current role, you also have
18 a social work qualification; is that correct?
19 **A. I do. I qualified as a social worker in 1978, and my**
20 **registration is current.**
21 Q. If we could just, before we start, set the context of
22 Ofsted, the Social Services Inspectorate was responsible
23 for inspection and monitoring from 1985 to 2004. They
24 were replaced by the Commission for Social Care
25 Inspection from 2004. When did Ofsted take over the

1 role of inspecting local authorities children's
2 services?
3 **A. Ofsted took over the role from 1 April 2007.**
4 Q. When we look at that role of inspecting local
5 authorities children's services, to be clear, that would
6 cover not only children's homes, but also foster
7 placements and adoption?
8 **A. Fostering agencies and adoption agencies, yes.**
9 Q. Yes, thank you. Turning specifically to, first of all,
10 children's homes, in Lambeth now, it would be the case
11 that nearly all of those would be out of borough; is
12 that correct?
13 **A. Yes. Yes, they would.**
14 Q. When we say "out of borough", how far are we talking, in
15 geographical distances? Is that just out of borough, or
16 very long distances away?
17 **A. There are about 2,500 children's homes across the**
18 **country, so some will be nearer to Lambeth than others.**
19 **London, as a region, doesn't have that many children's**
20 **homes, so the London authorities tend to use children's**
21 **homes not too far away from London, but looking possibly**
22 **towards Kent and in the south-east. But for particular**
23 **specialist placements, they may place children further**
24 **away in the country or may, on occasion, perhaps place**
25 **in Scotland or Wales.**

1 Q. We have heard evidence, this inquiry, from Lord Laming
2 that there was, in the past, a concern that children
3 placed a long way out of borough could be out of sight
4 and out of mind, a concern both in terms of cut-off of
5 family ties but also being insufficiently supervised
6 because of the geographical distance. Is that an
7 ongoing concern?
8 **A. It's something that we are certainly aware of when we**
9 **inspect, and so we will select a wide range of cases on**
10 **inspection, including some children who may be placed**
11 **further away. My understanding is that many of**
12 **the children placed by Lambeth are within 20 miles of**
13 **home. But, yes, we are very aware of that and we will**
14 **also look at their access to services such as CAMHS when**
15 **they're placed away from their local authority.**
16 Q. In fact, you refer in your statement to a 2016 case, and
17 that was one in the north of England in Sheffield, and
18 there were children in that case that made allegations
19 of sexual abuse. I don't intend to go into the details.
20 But in the notes on that case, it says:
21 "Failure of placing authority to support young
22 people placed a long way from home and out of area."
23 In that case, that, indeed, was a concern, that
24 there was a lack of support because of the geographical
25 distance?

1 **A. It was, yes, absolutely, but I think, no matter where**
2 **those children had been placed, I think we would have**
3 **been concerned, you know, wherever they were, given the**
4 **circumstances. It was as from the year before we**
5 **actually set up a system in Ofsted for children's homes**
6 **inspectors to contact us to let us know if there were**
7 **particular concerns about local authority practice when**
8 **they inspected children's homes, so we were able to join**
9 **up the system more tightly and get better intelligence**
10 **on local authority practice, and obviously we then raise**
11 **each case with the local authority in question, and will**
12 **take that information into account at the time of**
13 **the next inspection or visit.**
14 Q. Yes. With that case, just as an example, how was that
15 case brought to your attention?
16 **A. Well, that was a regulatory inspector who had oversight**
17 **of that particular service. It came to his attention**
18 **through an inspection I believe -- I'm not quite sure --**
19 **about the concerns about these children over a period of**
20 **time, and they were all placed by Lambeth and, because**
21 **I was the senior HMI in London that was linked to**
22 **Lambeth, he emailed me with that evidence, and then**
23 **I contacted the local authority -- well, the DCS, who**
24 **was very new at that time.**
25 Q. How did Lambeth respond when you raised the concerns

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1 with them?
2 **A. Well, we got an immediate acknowledgement from**
3 **Annie Hudson, the new interim DCS, and she was very**
4 **concerned. We got a further, more detailed response**
5 **within a few working days of making that referral. They**
6 **clearly had looked at that case, and they did**
7 **acknowledge that they should have taken more robust**
8 **action, which we would agree with.**
9 Q. In that case -- obviously those were children that were
10 placed by Lambeth and you raised the concern with
11 Lambeth, who responded. What is the situation if there
12 had been children from other local authorities? Is
13 there a joined-up process where those other local
14 authorities that may have children there would also be
15 informed, so there is a wider spread of the concern?
16 **A. Well, the way that our internal system works, when**
17 **a regulatory inspector -- and that's the title we give**
18 **to inspectors who inspect children's homes -- raises an**
19 **alert, they copy in all of the relevant senior HMIs from**
20 **the different regions, and so all the regions would be**
21 **alerted to the particular children affected within their**
22 **region. So we would all be able to see that, and we'd**
23 **all be able to record our findings and the responses**
24 **from the local authorities.**
25 Q. So if, for example, there was a problem with, let us

1 say, a member of staff in a home, it wouldn't just go to
2 the child involved; it would -- broader, all the local
3 authorities concerned would be informed?
4 **A. If there was a concern about a ...?**
5 Q. If there was a concern about a home, all of the local
6 authorities who had children there would be made aware
7 of the problem?
8 **A. If there was -- well, if there was a local authority who**
9 **had a child placed there and there was a concern about**
10 **that particular child, but certainly the regulatory**
11 **inspectors who inspect those homes on a regular basis,**
12 **they would hold that knowledge.**
13 **I mean, there are times, when we take enforcement**
14 **action against a home, when every local authority in the**
15 **country is told about that, because that is obviously,**
16 **you know, a very serious step for us to take, but we**
17 **wouldn't necessarily tell all local authorities who had**
18 **a child placed in a home of concerns with particular**
19 **children placed by other local authorities. Does that**
20 **make sense?**
21 Q. It does, yes. In terms of the availability of
22 placements, you say that special cases might involve
23 a child going a longer distance out of borough. Is
24 there, generally speaking, a shortage of placements? Is
25 it difficult to find placements for children in

1 residential settings?
2 **A. It can be very difficult to find appropriate placements**
3 **for children, absolutely. I think, certainly**
4 **since March of this year with the lockdown, that has put**
5 **pressures on local authorities. I think, when children**
6 **have got very complex needs, local authorities have to**
7 **give a lot of thought to the types of services that can**
8 **meet those children's needs, and then the particular**
9 **homes that they're looking at have to take into account**
10 **the other children that are already placed in that home**
11 **and whether it's an appropriate mix of children, and so**
12 **placing children in a children's home requires very**
13 **careful thought and complex commissioning at times.**
14 Q. Presumably, for children with particularly complex
15 needs, finding a place is exacerbated, it's even more
16 difficult?
17 **A. It can be, yes, extremely difficult. So we do see**
18 **children being placed in bespoke placements that have**
19 **been created, you know, specifically for them because**
20 **their needs are so complex and unique.**
21 Q. Is that shortage focused really around children's homes,
22 or does that translate across as well to foster
23 placements?
24 **A. I think -- I mean, it can also be an issue with foster**
25 **care. What we're seeing with local authorities is**

1 **that -- I mean, they're able to use independent**
2 **fostering agencies, who may be able to offer specific**
3 **types of placement, and some local authorities are also**
4 **training their foster carers to be able to provide**
5 **a specialist service and to be able to work with**
6 **children with particular needs.**
7 Q. The inquiry has been looking a lot at hearing children's
8 voices in inspections, and obviously in this case there
9 have been incidents of children who haven't historically
10 in the past been listened to. What are Ofsted doing,
11 and what do they do, when they conduct an inspection to
12 ensure that the child's voice is heard?
13 **A. Well, we do a range of things. First of all, we would**
14 **expect local authorities to be listening carefully to**
15 **children, and so we check with them what they're doing**
16 **to hear children's voices and to understand what**
17 **children have got to say. We also select a range of**
18 **cases, so the local authority will provide us with**
19 **a list of all their children who are in care, and we'll**
20 **select children of our own choice, and we will look at**
21 **the records in that case and, you know, if the child's**
22 **old enough, we may talk to that child and get their**
23 **feedback, and also, on our local authority inspections,**
24 **we will talk to a group -- if there's a Children in Care**
25 **Council, for example, we will always try to meet with**

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1 **representatives of the Children in Care Council, and**
2 **with a representative group of care leavers so we can**
3 **hear what they have to say.**
4 **Then, of course, when Ofsted inspects children's**
5 **homes, we will always try to meet with young people, if**
6 **they're prepared to talk to us, you know, either**
7 **individually or all together, to hear what they have to**
8 **say.**
9 Q. In relation to looking at the children's records, are
10 staff records looked at, as a matter of routine, or if
11 there were, as there have been historically in the cases
12 we have been looking at, rumours about staff, or Ofsted
13 pick up on a concern about a member of staff, are staff
14 records looked at as part of Ofsted's inspections?
15 **A. We'll look at staffing records in terms of fostering and**
16 **when we inspect fostering agencies and adoption**
17 **agencies. We don't look at local authority staffing**
18 **records, as a matter of routine, in our current**
19 **inspection framework.**
20 Q. Just going back to the theme of listening to the child,
21 obviously -- we have looked at case studies where we
22 have had children with communication difficulties. Is
23 that something that Ofsted engages in -- if you are
24 looking, for example, at a residential home where there
25 are either short-term care or long-term care for

1 children with complex needs, how would Ofsted go about
2 making sure those children are listened to and the
3 communication difficulties are overcome?
4 **A. I think if we're inspecting a -- like, a children's home**
5 **where perhaps children have sight difficulties or**
6 **hearing difficulties, we will have inspectors with**
7 **specialist skills who are able to talk to them, and we**
8 **have inspectors who have worked with children with**
9 **disabilities and are familiar with their communication**
10 **methods.**
11 **But, I mean, also, we will talk to the staff and to**
12 **check that they are skilled in working with children**
13 **with disabilities, and we have picked up on local**
14 **authority inspections sometimes that staff working with**
15 **children with disabilities aren't sufficiently skilled**
16 **to be able to communicate with them, and then we have**
17 **obviously raised that with the local authority to make**
18 **sure that that can happen.**
19 Q. So Ofsted themselves wouldn't, for example, use an
20 intermediary in order to facilitate an interview with
21 children in the same way you were speaking about,
22 speaking to a group of children who didn't have
23 communication difficulties?
24 **A. We do commission interpreters to work with us on certain**
25 **inspections. So some residential special schools, for**

1 **example, we commission interpreters to work with the**
2 **inspector for the time that they're on site so that we**
3 **can get the views of children.**
4 Q. Just staying with that group of children, obviously, who
5 could be particularly vulnerable, does Ofsted engage,
6 for example, with the Child and Adolescent Mental Health
7 Services to look at whether children in that setting may
8 have a change of behaviour, whether there are other what
9 might be seen as alerts to any problems with that home?
10 Is that the sort of thing Ofsted engages in at all?
11 **A. We don't directly engage with Children and Adolescent**
12 **Mental Health Services, because, obviously, our**
13 **inspectors for local authorities are current social**
14 **workers and are not health qualified, but we will talk**
15 **to the local authority about what's happening in terms**
16 **of CAMHS services, and we also carry out joint targeted**
17 **area inspections, where we work with CQC, the Care**
18 **Quality Commission, and we work with the police and**
19 **probation, and so, on those particular inspections, we**
20 **will take a multi-agency look at how those -- the**
21 **different professions are working together, and, you**
22 **know, we'll also have on our area SEND, our special**
23 **education needs and disabilities inspections, we will**
24 **also have a Care Quality Commission inspector with us,**
25 **and so we will look at those more widely, but on our**

1 **inspections of local authority children's services, we**
2 **will look at access to CAMHS, we will look at how long**
3 **children may have to wait to get an assessment, to get**
4 **treatment, but we don't directly make any judgment on**
5 **the quality of those services.**
6 Q. In situations where you do come across a safeguarding
7 issue, is there a period of how long you would allow
8 that home or that situation to improve? How would you
9 approach that in terms of the timing, the timescale,
10 that a failing service, particularly relating to
11 safeguarding, would be given to rectify the problem?
12 **A. It obviously depends on the seriousness of**
13 **the safeguarding issue. So we do have powers to take an**
14 **emergency cancellation, to apply to the court for**
15 **emergency cancellation. If we are so concerned that we**
16 **feel that the children can't remain there for another**
17 **night, then we could do that. We could suspend their**
18 **registration. We could place restrictions on the**
19 **service so that they can't admit any more children until**
20 **those issues are resolved. We can take a slower**
21 **cancellation route. So I think there are a range of**
22 **options. So as soon as the inspector raises concerns,**
23 **we immediately set up a case review in Ofsted. We**
24 **discuss what the options are available to us, how**
25 **serious the concerns are, and what action we are going**

to take. So we will take action very quickly, if we are very seriously concerned, and we will, and have, cancelled a registration through the courts when we have had those serious concerns.

Q. Just moving on to the issue of unregulated homes, so a situation where a 16- to 18-year-old is put in supported or semi-independent accommodation. That's something that it is our understanding is not covered at the moment by Ofsted inspections. Is that an area that is being looked at, particularly with the concern of a child, at 16/17, who might be open or particularly vulnerable to sexual exploitation?

A. The Department for Education have been consulting on that, but, as you say, it is not something that Ofsted inspect at the moment, so I can't really comment on that.

Q. If you could now look at the inspections that were carried out in relation to Lambeth. Fostering, first of all. There were inspections in 2009 and 2012, both of which were assessed as good. Is there another planned inspection specifically on fostering, fostering agencies, or is that now encompassed within the general inspection of children's services?

A. Yes. At that time, up until 2013, we carried out separate inspections of local authority fostering

services and local authority adoption services, but at that point, we introduced the single inspection framework, because, up until then, we had carried out inspections of the local authority, the fostering service, the adoption service and we'd been carrying out annual, unannounced inspections of contact referral and assessment arrangements.

So all of those were brought together into what became a four-week-long single inspection framework inspection, and that was the framework that we were using at the 2015 inspection, when we found services to be inadequate overall.

Q. I'm going to come to that shortly, but just so that I can complete that, so there were adoption inspections in 2008 and 2012, and they were respectively "good" and "outstanding". Then we come to, as you say, 2015. I wonder, Mr Hyde, if you could put up OFS012616_011.

This is the summary from the 2015 report. Just to put this in context, this followed a 2012 "outstanding" assessment; that's correct, isn't it?

A. It is.

Q. So at this stage, one has gone plummeting down to "inadequate", so down through the four stages to the bottom.

A. Yes.

Q. You see there in the summary, in the first paragraph, if maybe that could be enlarged, partway down that paragraph:

"However, responses to children who go missing or absent from home or care lack rigour. The increased vulnerability to all forms of exploitation for this group of children is not well addressed by front-line staff and managers. Children are not visited systematically when they return after going missing."

Then, if we could move down to the bottom of the page, please, in the final two paragraphs, we get at the bottom of the penultimate paragraph:

"This means that some children continue to live in circumstances that are harmful and neglectful for unacceptable periods of time.

"Turnover of staff has led to inconsistent and sometimes poor social work practice with some children, particularly in the disabled children's team."

So we have got there a very concerning and dramatic fall from 2012 to 2015. Did that indicate to Ofsted that, in fact, there should have been inspections in between or that, from Ofsted's point of view, there was something lacking in the inspection regime in order to get to that very concerning fall of standards?

A. Well, I think it -- I mean, it's certainly something

that we have reflected on, because it was a very dramatic fall. I think -- I mean, looking at the outcomes and the development of inspections between 2007 when Ofsted took on inspection of local authority services to 2012, there is a strong and an improving trend. As you have mentioned, the fostering and the adoption inspections went from good to outstanding, and there weren't indicators at that time that there were serious issues, and clearly, at the time of the 2012 inspection, services were extremely strong.

I think what we saw after that was, a number of senior managers who were in post in 2012 left the organisation. Some have gone on to become successful DCSs elsewhere in London, and I think the local authority did a significant reorganisation of services, and I think a lot of things changed. At that point, between 2012 and 2015, Ofsted -- we changed our inspection framework and we weren't carrying out routine inspections, and just looking at the serious incident notifications that came in during that time, there was not an unduly high number, and nothing that would have set alarm bells ringing.

So I think, you know, moving from that 2012 inspection to the 2015 inspection, when the local authority itself had assessed itself as "good", and

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1 **certainly didn't -- you know, was surprised at the**
2 **inadequate judgment --**
3 Q. That, of itself, suggests that the self-assessment,
4 certainly in that case, wasn't a very effective
5 mechanism?
6 A. **Yes, I don't -- I mean, clearly, they hadn't picked up**
7 **all the issues that we picked up when we carried out**
8 **that inspection. So I think what I'm saying is, it**
9 **would have been difficult to predict -- from the**
10 **information that we had, difficult to predict such**
11 **a fall.**
12 **With the system that we have at the moment, with**
13 **more frequent focused visits and with annual engagement**
14 **meetings with local authorities, we have more routine**
15 **intelligence of what's happening in local authorities**
16 **now. But, again, some of these things can be difficult**
17 **to predict, you know, until you go on site.**
18 Q. If we could just put up, Mr Hyde, on screen I think the
19 document we had up before. OFS012616_001 alongside
20 OFS012615_001. We should now come up on the screen with
21 the comparison. So we see there, on the left-hand side
22 of the screen, the report, or the summary of the report,
23 of 2015, and then we see alongside it the inspection of
24 2018. So we have got there the two. We see that there
25 is an improvement, in that it's gone from an overall

1 "inadequate" to an overall "requires improvement".
2 Between those two reports, there was a very
3 intensive, I think, eight monitoring visits by Lambeth.
4 Was that in some way a reaction to the reflection that
5 in the previous, between 2012 and 2015, there maybe
6 hadn't been sufficient monitoring visits in between
7 those two to alert Ofsted to the decline?
8 A. **Well, between 2012 and 2015, there was no facility for**
9 **monitoring visits. You know, Ofsted didn't carry out**
10 **monitoring visits. It was the end of one framework of**
11 **inspection and the beginning of another, so there was**
12 **nothing that would have happened in between. But at the**
13 **time of the 2015 inspection, Ofsted was beginning to**
14 **introduce improvement visits, and these were voluntary,**
15 **so they were offered to local authorities. So if they**
16 **wanted to take us up on the offer, initially it was one**
17 **day every month with an inspector just going in to check**
18 **on progress. So it was something that we were just**
19 **beginning to do, and that quite quickly became**
20 **formalised then into quarterly monitoring visits over**
21 **a period of time. It's now become established practice.**
22 **So we had a meeting with Lambeth to look at their**
23 **action plan, which was about three months after the**
24 **inspection, and at that point they were given the**
25 **opportunity to take advantage of these improvement**

1 **visits, and they decided that they did want to do that,**
2 **and so we started off with those improvement visits. As**
3 **I've said in my witness statement, initially, they**
4 **weren't published, but once the monitoring visit**
5 **arrangements were put onto a formal footing, then, from**
6 **that point on, the visits -- the reports of the visits**
7 **were published.**
8 **So we had the inspector who led all of**
9 **the monitoring work had been on the inspection herself,**
10 **and so she was very familiar with what the issues were,**
11 **and we had herself and a colleague who carried out most**
12 **of those monitoring visits between them.**
13 Q. How was, in terms of receptiveness, in terms of
14 transparency, how did Lambeth respond to Ofsted's
15 monitoring visits? As you say, it was a voluntary
16 thing, so they were obviously engaged with you.
17 A. **Yes.**
18 Q. But how would you explain their response? How would you
19 characterise their response?
20 A. **Actually, I think they responded very well. I mean, it**
21 **was heartening in the first place that, you know, they**
22 **were keen for us to come in and to work with them, and**
23 **we had, you know, free rein to choose what we looked at,**
24 **to select the cases and to talk to, you know, staff that**
25 **we wanted to talk to. But, as you will see from my**

1 **witness statement, we got very concerned after the third**
2 **improvement visit that we weren't actually seeing the**
3 **speed of progress that we needed to see, and we were**
4 **still very worried about the quality of services.**
5 **By that point, you often see when a local authority**
6 **is judged to be inadequate, you can see services decline**
7 **because staff move and there's a lot of uncertainty, and**
8 **I think services hadn't improved, and we just weren't**
9 **confident at that point that services were improving**
10 **fast enough.**
11 **So our regional director wrote to the**
12 **chief executive. The chief executive took it really**
13 **seriously. There was a meeting and things did change.**
14 **Annie Hudson was appointed soon after that.**
15 Q. You say there that things did change, but we have seen
16 in this inquiry a cycle of many, many reports
17 historically over time and many inspections, and yet not
18 sufficient improvement and, despite those eight
19 monitoring visits by 2018, Lambeth is still, and is
20 still at, a "requires improvement". So despite that
21 very intensive intervention by Ofsted to the monitoring,
22 and, really, it's your insight into what is the problem,
23 the ongoing problem, in terms of responsibility that,
24 despite the amount of inspections, there's still a state
25 in 2018, as we come to, where it's "requires

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improvement"?
A. **Well, I think in the first year following the inspection, there was obviously a lot of uncertainty and staffing instability and the DCS was interim. I think the appointment of Annie Hudson brought more stability and experience to the local authority, but she, herself, had to appoint senior managers and, you know, there has still been some turnover at senior management level, and obviously a new permanent DCS wasn't appointed until this year.**

So I think we saw improvements, you know, as from the middle of 2016, but, you know, we can see, through the progress of the monitoring visits, that, actually, some things were improving, some things didn't improve quite so well. By the time we got to the seventh monitoring visit, there were more concerns inspectors found at what we call the front door, where the referrals are handled, and so we decided, at that point, that we would do another monitoring visit.

So, you know, I think, from our point of view, we're going in, we're looking at the quality of the casework and we're providing feedback to the local authority, and then, you know, it's up to the local authority to take the necessary steps to strengthen their services.

You're quite right, the 2018 report, although the

inspection team found that overall the best fit for the service at the time was "requires improvement", there was still some inadequacy and there is still some way to go.

Q. Looking at where we are now, if I could just pull up on the screen OFS012621_001. This is the inspection that happened on 9 and 10 April 2019, if one highlights the first paragraph of that letter. So this was a year on from the 2018 "requires improvement" inspection, and we see then, if we could highlight the middle:

"A range of evidence was considered during this visit, which included discussions with social workers and their managers and looking at children's case files. Inspectors also met with independent reviewing officers ... and managers who are involved in public law ..." and so on, in that paragraph.

What it doesn't say in that paragraph which maybe you could clarify is whether any children were spoken to or whether children would routinely be spoken to at a monitoring -- or a visit like that?

A. **At a focused visit? I don't know whether children were spoken to on that visit. That's something that I can check for you. Inspectors would sometimes speak to the children for the cases that they select, but I can't honestly say.**

Q. If we just go down to the overview, if that could be highlighted, the paragraph under the word "Overview". It says there:

"The quality of permanence planning is improving."

It goes on to say:

"... there is still a considerable amount of work to do to ensure effective and timely permanence planning for young people ..."

We are at a situation at 8 May 2019, so that's 15 months ago, where the assessment is that it "requires improvement". When is the next inspection by Ofsted anticipated to be?

A. **All our inspections were suspended in March of this year, and so we haven't been able to visit any local authority since then. We are beginning to carry out focused visits again, as from September of this year, and so Lambeth will be considered along with every other local authority in the country as to where we need to go.**

As I mentioned in my witness statement, for an authority that requires improvement, we would normally carry out two focused visits between inspections where we make a judgment. So you will note on the focused visit letter that there is no judgment made. It really is to try to get a sense of, at a point in time, how

much progress is that local authority making?

We also discuss with local authorities which aspects of the service might be most helpful for us to look at and for them when we're carrying out these focused visits. Lambeth had said that because they knew they needed to improve their permanence planning that would be a very helpful area for us to look at. As you have seen, it was still a very mixed picture, and they still have some way to go on that, but without ascribing a judgment to it.

So they would have been due for a judgment inspection between -- within the next 12 months, really, before August 2021. I don't know exactly what's going to happen to that now.

Q. So is there any thought in Ofsted -- because obviously COVID, as you have said, has interrupted the inspection regime, and we have got a situation now -- so it will be, my understanding, at least, on the best-case scenario, they won't have been inspected for 18 months. Are there any alternative arrangements that are being put in by Ofsted, or is the plan simply to return to the normal inspection regime?

A. **I'm not sure yet when we'll be returning to the normal inspection regime. At the moment, we are looking across the country at all of the local authorities and are**

1 **identifying, you know, which ones of those are the ones**
2 **that we will look at sooner rather than later, and so**
3 **Lambeth will be considered as part of that.**
4 Q. There is just one point of clarity I have been asked to
5 request, just relating to one of your other questions.
6 You gave an answer, when I asked about children with
7 complex needs being spoken to by Ofsted inspectors, and
8 I think you used the word -- referring to using
9 interpreters. Can I just clarify, were you meaning to
10 refer to interpreters or intermediaries, so someone who
11 can assist with communication difficulties, or an
12 interpreter?
13 **A. Oh, when I was using the word "interpreter", I was**
14 **thinking in particular of, like -- residential special**
15 **schools for the deaf, for example, where we use signers**
16 **for that, as intermediaries.**
17 Q. But you would also, on occasions, would you, use
18 intermediaries, so someone who specialised in
19 understanding a child's particular communication
20 difficulties?
21 **A. "Intermediaries"? It is not a word that I hear used in**
22 **Ofsted. I can check that point for you.**
23 MS BROWN: Thank you very much. The panel may now have some
24 questions.
25 **A. Thank you.**

1 **Questions from THE PANEL**
2 THE CHAIR: Thank you, Ms Brown. Just a couple of points on
3 clarification from me. You referred to the period
4 between 2012 and 2015 when you said there was no
5 facility for visits during that period. Surely, just to
6 clarify, that didn't really mean that because you had --
7 something was outwith the working model of the then
8 inspection framework that you could not have initiated
9 such visits had you chosen to?
10 **A. Again, can I come back to the panel with clarification**
11 **on that, because I don't want to say something and then**
12 **it not be strictly accurate.**
13 THE CHAIR: It sounds -- my question is because it sounds
14 like rather a bureaucratic response, "Because it wasn't
15 in the framework we applied, therefore, we couldn't do
16 it", as opposed to based on an assessment of needs and
17 performance.
18 **A. Okay. I think what I would say is that, in 2012,**
19 **Lambeth was judged to be an outstanding authority with**
20 **no concerns raised. There was nothing came to light in**
21 **subsequent years to make us think that we ought to be**
22 **going in and speaking to the DCS and raising concerns**
23 **with this local authority. So in terms of our ongoing**
24 **risk assessment of that local authority, nothing was**
25 **showing that it was an authority that should give us**

1 **concern.**
2 THE CHAIR: But, in principle, you could have done so?
3 **A. I'm sure we could have done something.**
4 THE CHAIR: My second point is about the period following
5 the deterioration that you described. It is really
6 referring to the front-line staff's knowledge and
7 understanding of the processes of perpetrators and child
8 sexual exploitation, which seem to feature in missing
9 children and the other issues that you have described.
10 Were you convinced that staff were sufficiently well
11 equipped on the understanding of how to address these
12 issues?
13 **A. I think one of the issues that we found was, there was**
14 **quite a high turnover of staff, and so although -- so**
15 **you'd find that some staff had better understanding than**
16 **others, and from one visit to the next, because they had**
17 **a high number of agency staff, it might not always be**
18 **the same people there. So I think it would be difficult**
19 **to say.**
20 THE CHAIR: But, nevertheless, it was an emerging area of
21 concern across the country, and if people don't
22 understand the ways in which perpetrators operate,
23 they're not very likely to be able to address the
24 problem?
25 **A. No, and it was a frequent theme of the monitoring visits**

1 **that we -- inspectors came back time and time again to**
2 **child sexual exploitation and understanding of that.**
3 THE CHAIR: Thank you very much. I will ask my colleagues
4 now if they have any questions. Ms Sharpling?
5 MS SHARPLING: No, thank you, chair.
6 THE CHAIR: Mr Frank?
7 MR FRANK: No, thank you.
8 THE CHAIR: Sir Malcolm?
9 PROF SIR MALCOLM EVANS: No, thank you.
10 THE CHAIR: Thank you very much. We have no further
11 questions, Ms Adcock.
12 **A. Thank you.**
13 MS BROWN: Chair, if I might, then -- thank you very much,
14 Ms Adcock. That concludes your evidence.
15 (The witness withdrew)
16 MS BROWN: If I might ask to be uploaded the May 2015 and
17 the May 2018 inspections. The references for the
18 transcript are OFS012616 and OFS012615, and also the
19 letter of May 2019 about the focused visits of
20 9 and 10 April, that's OFS012621.
21 Ms Nice of counsel will now read in some evidence.
22 Statement of Witness LA-H1 (read)
23 MS NICE: Thank you, chair. I will read in evidence from
24 a statement and from the CHILE files. The statement is
25 that of LAH1, a woman who adopted children who had been

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1 in the care of Lambeth and at Angell Road, and the
2 relevant paragraph reads:
3 "I think we all suffered badly from the effects that
4 Angell Road had on the children. The childhood of both
5 children was not good, with three years of it being in
6 an abusive children's home with much older children.
7 The time spent with me was not the childhood I would
8 have liked them to have had, and I certainly was not
9 able to enjoy parenthood in the way that I had hoped.
10 "I was often very stressed by events and the
11 complete lack of support by Social Services. My
12 complaints were mainly ignored. I believe both children
13 could have been happier, more confident and higher
14 achievers if they had been in a safe, caring environment
15 as soon as they went into care.
16 "I believe if we had had the help we asked for when
17 one of the children's behaviour became so difficult, her
18 life could have taken a better turn, as could that of
19 the other child and my own."
20 Summaries of CHILE reports (read)
21 MS NICE: Turning to the CHILE reports, chair, in opening,
22 we referred to summaries of the reports prepared by the
23 counsel team. A small percentage of children who had
24 been in Lambeth's care were seen by Operation Middleton.
25 The CHILE file summaries have been prepared in place of

1 disclosing the files which contain highly sensitive
2 information about the children, their families and other
3 people involved in their lives. They have been prepared
4 in a wholly anonymised form and in order to reflect both
5 the concerns noted by CHILE and whether any concerns
6 were resolved. The core participants have the relevant
7 URNs and I will read in six of the summaries, beginning
8 with file number 29:
9 "These siblings were removed from foster care in the
10 late 1990s after allegations of physical abuse. The
11 CHILE file documents criticisms of how these children
12 were cared for by Lambeth. This includes the delay in
13 seeking care orders first raised in 1995. As regards
14 disclosure of sexual abuse, the file states that these
15 began when the child was 4 years old. There were
16 specific and serious allegations, 'no evidence the child
17 was even spoken to by anyone from the child protection
18 agencies'. As regards physical abuse, the child
19 disclosed physical abuse by the foster carer at school
20 in 1998, including that she had been punched in the face
21 while the foster mother held her down. She was less
22 than 10 years old at the time. 'The social worker did
23 not follow procedures, did not investigate the incident
24 with the child, the school or raise the issue in the
25 placement until 14 weeks after the event. Despite

1 physical marks being apparent on the child, she was not
2 seen by the social worker and no medical examination was
3 arranged'. It appears investigation into this
4 allegation was concluded without the child ever being
5 spoken to. No link worker was engaged until 20 months
6 after the placement started, the foster carer was not
7 offered any training on how to deal with sexually abused
8 children until over two years after the placement
9 started. She refused to attend. Siblings were sharing
10 a single mattress in a bunk bed. Later reports of one
11 child refer to it sleeping in a sleeping bag under
12 a table. The first mention of a review with the foster
13 carer was 23 months after the placement started.
14 "The records refer to five placements in five years
15 being cared for. Numerous issues were raised by CHILE
16 about the management of this case. 'Delays in
17 implementing decisions have had the most serious and
18 continuing repercussions. Disastrous consequences noted
19 for the children caused by the delay'. They were five
20 years after they last lived with their birth family
21 awaiting a permanent family without active steps having
22 been taken to begin the search. No system for child
23 protection conferences to feed into concerns about cases
24 to senior management. Despite the young age of these
25 children in the 2000s, CHILE thought the prognosis

1 looked very bleak."
2 The next case file is number 95:
3 "The child who is the subject of this file was in
4 Lambeth's care and lived at Birtley Farmhouse in the
5 early 1990s. Birtley Farmhouse was for teenagers with
6 therapeutic needs. This child was 7 years old when he
7 was sent there. He was supposed to be there on an
8 emergency basis. He was there for five months. Just
9 before he was placed there, Surrey County Council wrote
10 to the local authority Social Services Department
11 regarding concerns held about Birtley Farmhouse. This
12 letter was in the mother's file. He made allegations
13 that he had been sexually abused by a member of staff at
14 Birtley Farm. He was less than 10 years old when he
15 made this disclosure. The file contains conflicting
16 information as to where the child was placed at the
17 time. It appears from an affidavit from his social
18 worker that he was still living in Birtley Farm when he
19 made the disclosure.
20 "The file also suggests that the child made
21 disclosures when he lived in Birtley Farm about another
22 child's sexual behaviour towards him. The file states
23 that the department was to continue to pursue a further
24 placement of him as a matter of urgency but that he
25 should not be removed on a short-term emergency basis.

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1 The file also refers to media publicity about
2 Birtley Farmhouse in the early 1990s and the fact that
3 a child from Lambeth was placed there. This information
4 is contained in a letter from the Social Services
5 Inspectorate seeking report on the child. The file
6 states: 'The allegations referred to a 6-year-old boy
7 having been abused while at the home. There are other
8 allegations made including "ghost members of staff and
9 false records", et cetera. There was a reference to
10 a request of the High Court -- he was a ward of the
11 court -- for a disclosure interview to be carried out.
12 It appears that there was an interview about
13 Birtley Farm but the file does not record the outcome of
14 any investigation at the time. The child had been
15 referred to CHILE when he took his own life."
16 The next file is file 116. This file focuses on the
17 support which CHILE gave to the individual following her
18 coming forward and making a statement about her abuse.
19 The file conveys her disappointment at her case not
20 proceeding to prosecution. Some of the relevant
21 information can be found in the file of a sibling:
22 "There was a decision by the CPS not to prosecute in
23 2002, despite corroboration from the house mother. The
24 sibling's file demonstrates that the sexual assault of
25 the child was witnessed by the sister. The sister said

1 that the house mother came in during the assault. There
2 were concerns about the sister's ability to give
3 evidence. This file contains an interview with the
4 former house mother to these children. She referred to
5 the superintendent of Shirley Oaks who allowed one of
6 the siblings to be taken out by someone, but no name is
7 mentioned. She refers to the child as not wanting to go
8 with this man anymore. It appears that there was
9 a police investigation at the time which was 'written
10 off'. A man who filled in for the house mother was
11 accused of physically assaulting one of the siblings and
12 as having broken one of the child's limbs."
13 The next file is file 123:
14 "This file concerns a child in Lambeth's care in the
15 1990s. She was placed at Garrad's Road, had foster
16 placements and other placements. Whilst in foster care,
17 this child disclosed an incident of sexual abuse at
18 Garrad's Road. The record of the disclosure is in the
19 file. It relates to another child. She was approved
20 for adoption in the early 1990s. She was still with
21 foster parents seven years later. This individual
22 described to CHILE being moved around different homes
23 her whole life, being sexually and physically abused and
24 going through horrific incidents. She described her
25 pain at being torn apart from her sibling. Her sibling

1 was moved in a foster home where they were being bullied
2 and subject to violent treatment. The file refers to
3 this child having witnessed the rape of a very young
4 child by a much older child at a placement outside
5 Lambeth. She disclosed other incidents of abuse. It
6 refers to a member of agency staff at Garrad's Road
7 hitting one of these children. The file records the
8 children being told he would not be coming back to the
9 home. It also contains a number of disclosures by
10 children about being slapped or hit or other physical
11 violence by care workers. There is an account of
12 a meeting at the home. In response to these
13 disclosures, an assistant director said that the staff
14 should be talked to about acceptable methods of working.
15 At the meeting, managers at the home felt that the
16 position of staff whom children had disclosed had hit
17 them was untenable. 'In addition, the children had been
18 told that what they said would be taken seriously and
19 yet nothing seemed to have been done. The staff were
20 not suspended'. Observations on this file note that the
21 outcome of the investigation is not clear. There's
22 a separate file on the foster carers of this child. It
23 appears that a check by another borough revealed one
24 foster parent not to have disclosed a conviction for
25 dishonesty. It is not clear whether the allegations

1 made by this child about the foster parents resulted in
2 any action being taken. There is information about her
3 report of seeing a small child raped in a home outside
4 Lambeth. The file on the foster parent refers to
5 a police check being carried out in respect of
6 the foster carer's own child. Neither file makes clear
7 what this relates to."
8 File 168 relates to -- the individual who is the
9 subject of this file referred himself to CHILE. He was
10 in a foster placement in the 1970s with a family. CHILE
11 notes that a member of this family displayed an
12 unhealthy interest in teenage girls. CHILE researched
13 this family and found that they had fostered
14 72 children, largely on a short-term basis. Three
15 children stayed on a long-term basis. Two had learning
16 difficulties. These two children had been placed there
17 by another borough and stayed on after they were
18 discharged from care. There's reference to social
19 worker concerns about living conditions. They had no
20 aftercare whatsoever and cared for the foster carer,
21 doing the housework, the shopping, and so on. She says
22 it was Dickensian. One of these individuals, who had
23 learning needs, gave birth in circumstances described by
24 CHILE as extremely worrying. The child born under
25 'horrific circumstances'. The file states that the

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1 other borough made a complaint to Lambeth when it found
2 out about foster family member's interest in girls.
3 CHILE notes that the other borough social worker thought
4 this individual 'should sue Lambeth for her treatment
5 but was not able to'. The individual who is the subject
6 of this file, who was in Lambeth's care, disclosed to
7 CHILE that a member of his family used to take him and
8 another child to a depot and sexually abuse them. CHILE
9 was able to find files on only a few of the children who
10 had been fostered. The notes read as follows:
11 "A file on one child noted he almost implored me to
12 have him moved away. Anxieties about the foster
13 parents' care and the concern felt about family member's
14 overinvolved attitude towards adolescent girls did not
15 constitute a real barrier to ongoing placement as they
16 occurred many years ago. Although this foster carer
17 has, in the past, only been approved short term because
18 of the unverified allegations about the family member's
19 interest in adolescent girls and although she is not
20 young, the children, who are both ESN have progressed
21 remarkably in her care. Until puberty, at least, we
22 feel the children are not at risk here. Thereafter
23 a watchful eye should be kept, though the allegations
24 relate to a long time ago. The family member obviously
25 takes a tremendous interest in children, takes them out

1 a lot, is extremely involved in the upbringing of
2 the children."
3 Another quote:
4 "I have recently discovered some very worrying
5 information about the family member and his interest in
6 a foster child who was placed there ten years ago.
7 I have not been able to take this up. Please see my
8 writeup about this."
9 A reference to a police report expresses concern
10 about the "unhealthy interest the family member has
11 shown in adolescent girls". Finally, there is
12 a reference to a former foster child, who had remained
13 in this placement, giving birth unassisted in the
14 toilet, did not know she was pregnant, did not know who
15 the father was and had not had sex.
16 The last file, chair, is 195. This relates to
17 The Den in the late 1990s. It starts with a letter to
18 the child's social worker saying that she had been at
19 The Den for many years. It was intended as a placement
20 for children preparing for family placements. The
21 average stay was 18 months to two years. The file
22 refers to Croydon investigating The Den in 2000. There
23 was overwhelming evidence of poor quality childcare
24 practice. CHILE referred to Lambeth having paid in the
25 region of £350,000 to £400,000 for this child's

1 placement. There was no evidence of therapeutic work
2 having taken place. Little progress had been made.
3 CHILE notes concern as to why no permanent placement had
4 ever been found for this child:
5 "Delays which do not seem to have an easy
6 explanation have prevented this."
7 CHILE notes concern at this child being placed for
8 a long period at different homes not suited to her
9 needs. CHILE is critical of what was afforded to this
10 child at The Den and refers simply to unstructured art
11 therapy. There is a note from this child to her social
12 worker which the file says was "not heard". The note
13 reads:
14 "I would like to know why I have been at The Den for
15 so long and why I have not been found a family and why
16 you have not come to see me for so long. Please can you
17 write to me and tell me what is happening? Love from
18 [the child's name]."
19 Chair, that concludes the reading in of the CHILE
20 files. May I propose we break now and return at
21 a quarter to?
22 THE CHAIR: Yes, we will do that. Thank you, Ms Nice.
23 (11.31 am)
24 (A short break)
25 (11.45 am)

1 THE CHAIR: Counsel, please proceed.
2 MS BROWN: Thank you. If I could call Lord Patel, please.
3 LORD PATEL (affirmed)
4 Examination by MS BROWN
5 MS BROWN: Lord Patel, if you could just give your name,
6 please?
7 **A. It's Kamlesh Kumar Patel. Officially, it's Lord Patel**
8 **of Bradford.**
9 Q. Thank you. You gave a statement to the inquiry dated
10 12 February 2020. Is that statement true, to the best
11 of your knowledge and belief?
12 **A. It is true, to the best of my knowledge and belief, yes.**
13 Q. Lord Patel, you are currently Chair of Social Work
14 England. Previously, I think you have worked as
15 a social worker, you have been a senior lecturer in
16 social work. Since 2012, you have been a Professorial
17 Fellow of Public Health at the Royal Society for Public
18 Health and Mental Health and you're currently President
19 of the Royal Society for Public Health. Is that
20 correct?
21 **A. That's correct. My social work experience dates back to**
22 **the 1980s, early '80s.**
23 Q. Dealing briefly, first, with the history of regulation
24 of social workers, you set out in your statement that
25 the statutory regulation of social workers began in

1 2001, with the General Social Care Council; that was
2 replaced by the Health and Care Professions Council in
3 2012; and Social Work England became the regulator on
4 2 December 2019. Is that your understanding?
5 **A. That's correct.**
6 Q. If we could turn to paragraph 7 of your statement, you
7 set out there the four functions of Social Work England,
8 and they are these: maintaining a register of social
9 workers; publishing professional standards for social
10 workers; setting standards for the education and
11 training of social workers; and, finally, taking
12 disciplinary action against social workers where their
13 fitness to practise is impaired.
14 If I could go to paragraph 8 where you set out
15 Social Work England's overarching objective, you say the
16 overarching objective is protection of the public, and
17 you put then the three objectives: first, to protect the
18 public; second, to promote confidence in social workers;
19 and, third, to promote and maintain proper professional
20 standards in social workers.
21 Lord Patel, I wonder if you could help us, first,
22 protection of the public, and obviously specifically as
23 far as this inquiry is concerned, protection of children
24 and vulnerable children. How is Social Work England, as
25 a regulator, fulfilling that overarching objective to

1 protect the public and children in particular?
2 **A. I think in several ways. One is, we have developed**
3 **professional standards, and I think the professional**
4 **standards are at the core of everything we do and the**
5 **heart of everything we do. There are sort of six broad**
6 **areas that cover a range of topics, and they have been**
7 **developed with the profession. I can talk more about**
8 **that if you want me to.**
9 **But I think ensuring that every social work**
10 **professional understands those standards, understands**
11 **why we have them and that they adhere to them.**
12 Q. Just dealing specifically with those standards, in this
13 inquiry we have been looking at and seen examples of
14 lack of leadership, and indeed a lack of taking
15 accountability for decisions. How central is that to
16 your professional standards?
17 **A. Very central. If I sort of just give the broad six**
18 **parameters, I think it is about promoting the rights,**
19 **strengths and well-being of families and having that at**
20 **the forefront of your mind; the ability to establish**
21 **trust and confidence with the people you're working**
22 **with; and to your point, being absolutely accountable**
23 **for the quality of practice and decision making. Linked**
24 **to that, and I'll come back to it, is the maintenance of**
25 **your continual professional development, which I think**

1 **is another very discrete area that we need to build**
2 **upon. The need to act safely, respectfully and with**
3 **professional integrity, and I underline that word. And,**
4 **of course, promoting ethical practice and the ability to**
5 **report concerns within yourself or within others.**
6 **So I think, you know, a lot of the issues, when you**
7 **look back at the history, we have had lots of different**
8 **standards in lots of different places, and I think the**
9 **profession has sort of been torn and some people have**
10 **latched on to what feels comfortable. We have brought**
11 **everything together in one set of standards, and we took**
12 **pains to engage with thousands of people in the**
13 **development of those standards, as well as, at the end,**
14 **people have lived experience of social work, and they**
15 **were actively engaging -- again, I can give you**
16 **information on that if you require it.**
17 Q. Having set those standards, how, in very practical
18 terms, are you ensuring or working with those --
19 training social workers to ensure those standards are
20 understood by all those who are being trained in the
21 profession and, as you refer to continuing professional
22 development, that they are the ongoing standards? In
23 practical terms, what is Social Work England doing to
24 make sure that is happening?
25 **A. So I think there are three separate elements to this.**

1 **We have set up a -- currently, we're using the education**
2 **and training standards that we inherited from the**
3 **healthcare professions, but we've written, again, in**
4 **full consultation with training and education providers,**
5 **a set of standards to ensure that all those coming into**
6 **the profession understand what the professional**
7 **standards are and the educators are ensuring that the**
8 **standards are met and developed and they're producing**
9 **a student who can be ready for social work practice.**
10 **Then we have a separate set of standards on**
11 **continual professional development. So if I just**
12 **concentrate a little bit on the continual professional**
13 **development, we are expecting that every social worker**
14 **will be registered annually, and they will have to**
15 **produce evidence of the sort of eight broad areas of**
16 **continual professional development.**
17 **Of course, we have only been operating for six**
18 **months and this is something quite new that's not**
19 **happened before. Before, people needed to sort of**
20 **report on their continual professional development, and**
21 **a very small percentage were sort of chosen to validate**
22 **they were telling the truth. We are requiring every**
23 **single person, in order to be registered on our**
24 **register, to create a social work account on our website**
25 **and fill in on our website what they have done and what**

they have learnt and how they have reflected and how they're continuing professionally to develop.

Over the next few years, we will take all that evidence and we will work with the profession to enhance the CPD provision. But our expectation is, the moment you work -- you walk through an education course to the moment you retire, you will continue to professionally develop your practice.

Q. You referred there to the social workers who have registered with you and we have seen the up-to-date figures -- it is something over 98,000 social workers who are now registered with Social Work England.

At paragraph 50 of your statement, you talk about the fact that it is the responsibility of the individual social workers to make sure that they are registered with you and that Social Work England doesn't have legislative powers in relation to employers to register, it is the responsibility placed on the social worker. Was that a very conscious decision or is there potentially a problem there?

A. It wasn't, certainly, a conscious decision on Social Work England's part. That was the legislation that enacted that, so we're following the legislation.

I think we have taken a number of actions to sort of cover that area. One is, when I started, in 2018,

from April 2018 to when the next appointment was made almost five to six months later, I spent six months talking to over 2,000 people, that included employers, other regulators, unions, professional organisations, service users, and the public, about -- to raise awareness of this issue. When we developed the standards, we talked to a lot -- like I said, thousands of people, about what needs to happen. So I think we've been pushing out through media, through social media, through print, our existence and what employers need to understand, and many of them, employers, I suppose, the managers, will be registered social workers, so they will know that needs to happen.

Q. Clearly, it has been successful, because you've got 98,000 social workers registered.

A. Yes.

Q. Going on to that, you mention -- this is, again, in your statement -- that it is your expectation with -- this is paragraph 50 -- your expectation that employers will use the register as a means of checking that social workers are indeed properly registered. Is that something that you have monitored, that you're aware that employers are taking up that, or that's an aspiration, or is that happening, in fact?

A. I would expect that any employer with any decent policy

in place will have a sentence that said, "Check the SWE" -- I would imagine that employing a social worker in your organisation you would want to have on record their registration number, not only to check whether they're registered, but to check whether there's any sanctions that have been annotated on our register.

Q. You have anticipated my question, then. If an employer were to check and there were to be any condition on their registration or any interim suspension, for example, that would be visible immediately to the employer?

A. Absolutely, yes.

Q. Whilst that would be visible to the employer if they proactively go and check the register, if, for example, a social worker has a condition placed on them, do Social Work England go out to the employer to inform them of that, or would the employer discover that by proactively looking at the --

A. No. I suppose we wouldn't know who is employing who at any one time. But we have the power to annotate on our register, on our public register. So you would see that the person is potentially -- well, would have a degree in social work, may have advanced qualifications, and maybe three years ago, or last year, they were suspended for four weeks because of something.

Q. And that would be visible to an employer?

A. That would be visible, yes, to anyone.

Q. To anyone?

A. Yes.

Q. Just dealing with declaration of offences, and you deal with this at paragraph 52 of your statement, again, the onus is on the social worker themselves to make a declaration if they -- obviously, we are, in this inquiry, concerned with schedule 1 offences particularly, but indeed it's any offences they would have to declare, and that's a continuing obligation. Is there a concern, is it something that Social Work England considered, where you would come across a social worker who is deliberately concealing the fact of an offence? It does, doesn't it, rely on their honesty of declaring the conviction?

A. It does, to a large extent, absolutely. But we have a number of protocols in place, so, you know, we regularly liaise with other regulators, with the police, with ombudsmen, we have MOUs in place, barring services. Somewhere along the line, if that person had had a conviction, it would be flagged up to us that they're a social worker and it's happened. So we monitor constantly, we engage with all the other regulators and other professional bodies across Europe, in fact, as

1 **well, to make sure that will be flagged, and if it is,**
2 **of course we'd deal with it straight away. There's**
3 **a possibility somebody may go under the radar and then,**
4 **you know, we hope, if that comes to light, one of their**
5 **colleagues, their managers, or somebody, will raise**
6 **a concern.**
7 Q. But you don't, for example, have a system where a social
8 worker would have to, themselves, produce a DBS check or
9 something like that?
10 **A. One assumes that the DBS check would be done by the**
11 **employer.**
12 Q. But that's not something that Social Work England --
13 **A. No, we wouldn't.**
14 Q. You spoke there, and it leads me on to my next question,
15 about you would hope that people who had concerns, for
16 example, about another -- a fellow social worker or
17 members of the public, can raise concerns, and you deal
18 with that at paragraph 76 of your statement, where you
19 say that there's an electronic form on the website where
20 members of the public could raise concerns, ideally
21 using an online form, but I think you're open as well to
22 telephone and email and letters.
23 **A. Yes.**
24 Q. Presumably, that is to be as wide as possible to all
25 ranges of people with differing abilities with

1 technology to ensure that you have an open door to their
2 concerns?
3 **A. 100 per cent, yes. It's really important. Ideally,**
4 **technology and data would help and make things -- but**
5 **any way, shape or form, in a sense, will ensure somebody**
6 **can make a concern.**
7 Q. What about children in this? Obviously, that's what our
8 inquiry is concerned with. There may be a child that
9 has a concern. We have heard in this inquiry children
10 who had concerns and weren't listened to. What if
11 a child wanted to or tried to contact you? Are there
12 procedures in place as to who would speak to that child
13 or how that would be dealt with?
14 **A. We have extensively trained people to take these**
15 **concerns and register them. We'd have all sorts of**
16 **protocols in place. I can't detail them completely, but**
17 **we ensure there's -- you know, every safeguard we could**
18 **have in place to ensure that a child could do this**
19 **safely and --**
20 Q. That is something that Social Work England have thought
21 about, that it might be the child raising an issue?
22 **A. Absolutely. Or a vulnerable adult, maybe, with learning**
23 **disabilities or other. So I think, absolutely, and**
24 **I think that's -- would be a real priority for us in**
25 **order to safeguard the person concerned and supporting**

1 **them through that complaint as well.**
2 Q. Obviously you're a new organisation. You're talking
3 about what you would hope. Is there a protocol in place
4 at the moment, or is that something that's under
5 development, in terms of how you deal with, as you say,
6 a vulnerable adult or a child contacting --
7 **A. I would -- I wouldn't be 100 per cent sure there's**
8 **a protocol in place, but I'd be very surprised if there**
9 **isn't, considering all the guidance, considering all the**
10 **training we have had and the external people who have**
11 **come in and trained all our partners and workers.**
12 Q. If I can go now, while we are still on this issue of
13 someone raising concerns with you, at paragraph 78 you
14 say:
15 "As stated above, Social Work England's powers of
16 regulation do not extend to employers and it is not able
17 to require an employer to refer a concern. However,
18 Social Work England will work closely with employers,
19 including local authorities, to ensure that they are
20 aware of the need to raise concerns in order to ensure
21 the public is protected."
22 So, of course, here there could potentially be an
23 issue of a social worker, let us say, being dismissed
24 from one authority and moving to work elsewhere.
25 Obviously one of the guards against that would be if the

1 employer who unearths a problem communicates with you,
2 and you say you're working to raise concern. What steps
3 are Social Work England taking with regard to employers
4 to make sure they are aware that, if they have concerns,
5 they should raise them with you?
6 **A. So a couple of things. I suppose the one very obvious**
7 **issue is back to the professional standards, because if**
8 **a social worker is dismissed, then they will be**
9 **supervised by a social work manager, and it's the duty**
10 **of that social work manager to report any concerns about**
11 **a colleague's or an employee's fitness to practise and**
12 **issues, so that would automatically happen because they**
13 **should know that because they'd be following the**
14 **standards.**
15 **We have also done -- undertaken some innovative and**
16 **creative work. We have employed some regional**
17 **engagement leads. So we have eight**
18 **social-work-qualified people work in eight regions of**
19 **the country. Their job is to absolutely engage with**
20 **employers, with higher education institutions, with**
21 **people with lived experience, and draw attention to our**
22 **work and what employers and others should do in a very**
23 **proactive way.**
24 Q. You talk there about a social worker or supervisor
25 reporting if there was a concern about a colleague.

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1 Under the professional standards we were talking about
2 at the beginning, is there an obligation on social
3 workers to report colleagues if they're aware that that
4 colleague is acting in breach of your professional
5 standards?
6 **A. Yes, very clearly. Very clearly in a number of elements**
7 **of the standards.**
8 Q. If I could move now, Lord Patel, just to look at some of
9 the figures. I'm aware that your colleague,
10 Jonathan Dillon, who is the executive director, has
11 produced a witness statement, and in due course I'll be
12 asking for that witness statement to be uploaded, but if
13 I could just look at some of the very headline figures
14 in that. We have gone already to the registration,
15 which is -- 98,000, I think he gives the precise figure
16 of 98,236 social workers registered as at the date of
17 his statement. But with regard to the concerns that
18 have been raised, at paragraph 6 of his statement, he
19 states that between 2 December 2019, when Social Work
20 England became the regulator, and 30 June 2020, "The
21 concerns we have received from the public have resulted
22 in 1,150 referrals being generated"; you know, a very
23 substantial sum. Then we see, at paragraph 7
24 underneath, that's in addition to 1,472 -- I think you
25 refer to legacy cases; that is, cases still outstanding

1 from the previous regulatory body and which you
2 inherited?
3 **A. Yes.**
4 Q. There's a lot of figures in this statement, but, in
5 essence, it appears that, on average, the age of those
6 legacy cases is, they say, 343 days, so approximately
7 a year old. That, in terms of the child, if we are
8 looking at a situation with the child or a vulnerable
9 adult, and indeed in terms of the social worker who's
10 had the issue raised against them, is a very
11 considerable delay. What does Social Work England do to
12 ensure that, first of all, the child is appropriately
13 safeguarded, and indeed other children who may be at
14 risk if there is a serious complaint brought against
15 a social worker, for example?
16 **A. Just for a bit of clarification as well. So we have**
17 **approximately just over 98,000 registered social workers**
18 **and we have, in addition, currently just under 9,000**
19 **social workers who are registered under the emergency**
20 **legislation for COVID, so they're on there as well.**
21 **It feels, or it appears from when the HCPC were the**
22 **regulators of social workers, approximately 2 per cent,**
23 **2 per cent plus, of the social work profession came into**
24 **a fitness-to-practise regime, which seems to sort of**
25 **tally with the sort of first six months of our**

1 **progression.**
2 **We have a series of stages, so we have somebody who**
3 **raises a concern and then we triage that case, which**
4 **could take, you know -- investigate, four to six weeks,**
5 **and then, if they thought it was going to meet certain**
6 **thresholds, it would go to some case examiners who would**
7 **then look at the evidence and then decide on a range of**
8 **disposal mechanisms or send it to the adjudicators for**
9 **a hearing.**
10 **If, at the triage stage, right at the concern stage,**
11 **it was something that was to do with a vulnerable child**
12 **or even a vulnerable adult, we would accelerate that**
13 **process straight to the case examiner, so we -- you**
14 **know, it may mean an interim suspension while we**
15 **investigate. You know, we may have to wait for**
16 **12 months for the police to carry on an enquiry, but we**
17 **would ensure that that's accelerated immediately.**
18 Q. Interrupting that, so four to six weeks for the triage
19 stage. So if a very serious complaint within a window
20 of four to six weeks --
21 **A. If a very serious complaint --**
22 Q. -- (overspeaking) would be addressed?
23 **A. Sorry, apologies. If a serious complaint came in,**
24 **I would hope we'd be doing that in days, not weeks.**
25 **Because I think we'd have to escalate it to ensure the**

1 **vulnerable person is protected, first and foremost, and**
2 **then conduct our investigations.**
3 Q. Obviously this is looking to the future, but we know
4 that there are these 1,400-odd legacy cases which are
5 already a year old. What is being done in relation to
6 those in terms of the protection of the child, but also
7 the social worker who may, I presume, in some cases, be
8 suspended?
9 **A. I mean, in my view, you know, such legacy cases are**
10 **unacceptable for everyone: the professional involved,**
11 **the people who have complained. Unfortunately, the**
12 **legislation at the time was such that it took a long**
13 **time to deal with these cases.**
14 **We have reviewed every single one of those, and we**
15 **are now attempting to get them to an end proposal as**
16 **soon as possible. COVID obviously has hampered some of**
17 **our personal hearings. We have also brought in some**
18 **extra help from Capsticks, the lawyers, to help**
19 **accelerate those legacy cases because the potential is,**
20 **it will destabilise our own process for new cases and**
21 **how we can move rapidly there.**
22 Q. I should just go back to clarify something you said so
23 we can make that clear. You have said you had some
24 emergency registration social workers regarding COVID.
25 I don't want to go into a lot of detail about this, but

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1 could you just explain what you meant by that?
2 **A. Just like asking nurses or doctors who may have retired**
3 **to come back into the profession to help, there was**
4 **a call for social workers who may have retired or left**
5 **but still had the required standards to come back and**
6 **work on an emergency basis until the current pandemic**
7 **ends.**
8 Q. They would have been subject, would they, to the same
9 obligations, for example, declaring any criminal
10 offences?
11 **A. Completely, yes. They would have gone through the same**
12 **process to register on our register as any current**
13 **social worker.**
14 Q. We have dealt, really, with the legacy cases, but in
15 terms of the new cases, so obviously an enormous number
16 of referrals have come in -- 1,150 have been generated.
17 Looking at Mr Dillon's statement, since December 2019,
18 only 27 of those cases have reached a final decision.
19 Now, on the face of it, that suggests that a backlog is
20 building up very rapidly of cases. What's Social Work
21 England doing to ensure that cases are moved through the
22 system at appropriate speed?
23 **A. I suppose the backlog is dealing with the legacy cases,**
24 **has been our problem. We have brought in extra support**
25 **to deal with that. I think we have still set our**

1 **timescales and we are meeting them at the moment. If**
2 **that begins to fall down, we will bring extra support in**
3 **and, as I said, we have Capsticks that help us out at**
4 **the moment to get us up to speed in terms of disposal of**
5 **the legacy cases and then dealing with our timelines.**
6 Q. Yes. I think it's paragraph 9 of Mr Dillon's statement.
7 He sets out the aspirations of the timescales, to triage
8 decisions, six weeks; triage to case examiners, four
9 months; and case examiners to hearings, six months.
10 **A. Yes.**
11 Q. Really, my question is that, given 1,150 registered and
12 only 27 final hearings, that falls a long way short,
13 even without doing a detailed analysis, of the target at
14 the moment. Is there a concern that the system is going
15 to, in effect, collapse under its own weight?
16 **A. I think the fitness to practise team are fairly**
17 **confident that we will accelerate our process and catch**
18 **up and stick to that timeline. I suppose my**
19 **responsibility and the board's responsibility will be to**
20 **make sure that we regularly receive details on that and**
21 **ensure those timescales are kept to, and actually**
22 **improved, and if the resources are needed, then that**
23 **will be provided. At the moment, we are fairly**
24 **confident we will begin -- I completely take on board --**
25 **there's only 27 there, but I think the pace at which**

1 **we're moving and the ability to dispose of many, many**
2 **cases at triage stage is very different to building up**
3 **a legacy case.**
4 Q. With those -- the numbers of new cases that have come
5 in, you said that you'd reviewed the legacy cases to
6 ensure that there were -- if there were any serious
7 concerns or safeguarding issues. Have the cases that
8 have come in since Social Work England -- what has been
9 done to ensure that anybody coming in with a complaint
10 that raises a safeguarding issue of a child has been
11 addressed? Is that being addressed on a sufficiently
12 fast rolling basis, so within six weeks?
13 **A. Yes. All of them will have been triaged. If in that,**
14 **as I mentioned earlier, there was a safeguarding issue,**
15 **that case will be accelerated immediately and --**
16 Q. How does that happen in practice? Who is it who is
17 getting the complaint in and reviewing that?
18 **A. We have a team of triage experts, and then we have**
19 **internal managers and Jon himself as well. They would**
20 **review that and that will be flagged up immediately.**
21 Q. It wouldn't be a case of something at the moment of
22 a stack of letters or stack of emails --
23 **A. No.**
24 Q. -- that simply wasn't dealt with for maybe weeks or
25 months?

1 **A. Absolutely not. Just to prove a case in point, we**
2 **obviously get concerns from employers, from the public,**
3 **from other social workers. We are also -- so last week,**
4 **we saw something in the media that raised our concerns**
5 **and we followed it through to ask for evidence from the**
6 **local authority because the social worker wasn't named**
7 **in court. But we followed that through because we think**
8 **it is a safeguarding issue around child protection.**
9 Q. So Social Work England are actually proactively
10 operating --
11 **A. We'd been the -- the concern raised, as it was, from**
12 **what we have heard.**
13 MS BROWN: Thank you very much, Lord Patel. I have no
14 further questions, but the chair and panel may have.
15 Questions from THE PANEL
16 THE CHAIR: Thank you, Lord Patel, I have some questions.
17 You may or may not be aware that this inquiry in its
18 interim report in 2017 made recommendations for the
19 regulation of the children's homes workforce. Now,
20 I appreciate that you are very busy with, you know, the
21 new body being set up and the backlog, et cetera.
22 However, we regarded it as such an urgent issue because
23 of what we have found throughout this inquiry's time,
24 and also because, of course, it is required in the three
25 other parts of the United Kingdom. So have you any

plans for setting up children's home workforce regulation?

A. So I think we've got two very concrete plans, I think, that are really important to this inquiry. I believe there's approximately 35,000 social care workers in children's homes, and they're not regulated by anybody. I absolutely believe that we have the infrastructure, the processes, to be able to register those 35,000 individuals and give them the same conditions that we give social workers in terms of their professional standards, of their continuing professional development. That links to something else for me, is the registration of students. Because, as I have gone around the country and spoken to lots of students, (a) I think the world should begin when you walk through that education door and you should understand what your responsibilities are and you should inherit this sort of practice of continually developing and learning, and you should understand your responsibilities and your standards from then and they should carry on until you retire.

My one anxiety was where students fall out of courses and nobody has it registered anywhere that, you know, Mr A left this course under a cloud and they have gone. Then six months later, or a year later, they emerge as a care worker in a residential children's

home, and nobody would know that.

I think, one, we should register students, not only for the pipeline and the better quality and raising standards, but for the protection of the public. I think absolutely there should be a process of regulating care workers in children's homes.

THE CHAIR: Yes. I was about to ask you about social work students, because I failed to understand why they were dropped from the registration categories in England at an earlier stage, when they were at one point registered. So I would agree that social work students -- not just for the reasons you say, but because, of course, they spend a great deal of time, correctly so, in practical placements.

A. Absolutely, and I think the General Social Care Council did register students. They also provided guidance to the wider care workers. That has all gone, when it transferred to the HCPC. So I think there's not a logical reason why we shouldn't register students and begin that process of development and safeguarding the public, because, as you say, they'll be working with vulnerable people during their placements, even though they should be supervised very heavily by not only their tutors, but their practice teachers.

THE CHAIR: Are you in a position, notwithstanding the

backlog you have to deal with, to say when you and your board will consider the regulation of the children's home workforce?

A. I would love to do it quicker than most people would, but it's not in our power or gift to be able to do that. It would be the two departments that we work with, in terms of the Department of Education and the Department of Health and Social Care, who would have to give us those powers to regulate the children's care workforce.

And of course we'd bring in extra resources. I don't think the fitness to practise element would be of great concern, because all the other infrastructure -- the registration, the standards, the professional team, the fact we have panels already looking at that -- is in place to be developed fairly rapidly.

THE CHAIR: Thank you. Yes, I understand that point. Just to note, of course, that in Scotland, for example, this has been required since the year 2009, when registration of the residential workforce began, and in a phased way, so, as you know, it's not necessary to bring the entire workforce on at a single point. So it is very important -- and not just that, but in Scotland there's 21 categories of Social Service workers who are regulated by the Scottish Social Services Council. So

there is a great deal of work potentially to be done. I do understand, of course, that you require these powers to be given to you.

A. If I may, Professor Jay, I know this is about children and children's homes, but if my memory serves me right, around 30 per cent of people, vulnerable adults who are abused, are abused by their carers, professional carers. So I think there's an issue in terms of, whereafter do we go and what do we regulate and who regulates that. The other thing that impacts on all of this is our ability to collect data, so if you look at what we put on our register, it's a very minimum, basic data. I could not tell you, very unhappily, that of the 98,236 social workers, how many are men, how many are women, what ages they -- I could tell their ages. What ethnic background they have, whether they -- which course they came from and how long they've been in social work, whether they're children or mental health or adults, and I think we need that data to inform the workforce, to inform our idea about which courses are effective and not effective, and a whole range of other issues. But I think all those go together.

THE CHAIR: Thank you. I will ask my colleagues whether they have any questions. Ms Sharpling?

MS SHARPLING: Yes, please. Thank you, Lord Patel. Just

1 one question. You have touched on it in your statement
2 but I just wondered if you would clarify this for me: if
3 a social worker is charged with a criminal offence,
4 perhaps relating to child sexual abuse, and that social
5 worker is acquitted at trial, what is Social Work
6 England's response in such a circumstance?
7 **A. I think there are two things. (a) if they were**
8 **acquitted, then we would carry on with our**
9 **investigation, because I think the level of evidence**
10 **needed in a criminal court would be different to the**
11 **level of evidence for us, in terms of how that person**
12 **has met their professional standards and their integrity**
13 **and their actions. But we would go through the process**
14 **that I outlined earlier in terms of investigation.**
15 MS SHARPLING: Thank you. That's most helpful.
16 THE CHAIR: Mr Frank?
17 MR FRANK: No, thank you.
18 THE CHAIR: Sir Malcolm?
19 PROF SIR MALCOLM EVANS: No, thank you.
20 THE CHAIR: Thank you very much, Lord Patel. We have no
21 further questions.
22 **A. My pleasure. Thank you.**
23 MS BROWN: Thank you, Lord Patel. That concludes your
24 evidence.
25 (The witness withdrew)

1 MS BROWN: Chair, if I may, if I could ask that both
2 Lord Patel's statement, INQ004979, be uploaded in its
3 entirety, and Jonathan Dillon's statement, INQ005988,
4 also be uploaded.
5 Chair, if I may deal with just two additional
6 matters regarding statements that the inquiry have
7 received dealing with matters that have occurred during
8 the hearing.
9 The witness Clare Whelan was asked, when giving
10 evidence, whether she had seen the document entitled "An
11 Independent Review of Procedures for Dealing with
12 Allegations of Child Sexual Abuse in Establishments run
13 by Lambeth Council: An Interim Report", and the
14 reference is INQ004910. That was the report, the chair
15 and panel will recall, that was produced by a Special
16 Review Panel, chaired by Mr Palayiwa, following the
17 Ivy House allegation. Ms Whelan was provided with
18 a copy of that report, along with two documents to set
19 it in context, a report of the Social Services Committee
20 of 24 March 1987, LAM000012, and a memo of
21 the Social Services Inspectorate of 27 October 1987,
22 CQC000126, subsequent to her giving evidence so she
23 could consider whether she had indeed seen that report
24 which has been an issue for the inquiry. She said this
25 in response in her statement to the inquiry:

1 "I confirm that I have reviewed the above documents.
2 I have no recollection of seeing the documents before.
3 As I was only elected as a member of the council in
4 1990, it seems unlikely that I would have done so unless
5 someone deliberately brought them to my attention
6 sometime after the period in which they were written and
7 I cannot recollect that having happened."
8 That just concludes that loose end with regard to
9 whether she had seen that report.
10 Chair, then, with your permission, I will now read
11 in a supplemental statement that's been provided to the
12 inquiry by Mr Osmond. That was produced in response to
13 a number of questions that were asked relating to his
14 visits to Angell Road, his knowledge of
15 Michael John Carroll and his knowledge of an allegation
16 by LA-A213.
17 Just by way of background regarding LA-A213, there
18 was a memo dated 10 April 1979 from Mr Osborne [sic]
19 that shows he received a telephone call reporting an
20 allegation of sexual abuse made by a child in Lambeth's
21 care against a foster parent. The memo from Mr Osmond
22 was marked "urgent" and was a referral of the matter by
23 Mr Osmond to Ms Howarth, the Assistant Director of
24 Social Services at the time. A letter of 11 April 1979
25 from the assistant education officers to Mr Osmond set

1 out further details of the allegation. A memo from
2 Ms Howarth made it clear that the social worker had
3 already been contacted, had contacted her, and that the
4 child, LA-A213, had been removed from the foster parents
5 and Mr Osmond was copied in to a subsequent letter to
6 the foster parents.
7 Third statement of MR ROBIN NICHOLAS OSMOND (read)
8 MS BROWN: With that background, then, I will read, if
9 I may, the statement, the third statement, of
10 Mr Robin Osmond in which he says in relation to these
11 issues:
12 "I Robin Nicholas Osmond make this third statement
13 further to the letter from the inquiry dated
14 17 July 2020. I am asked questions relating to two
15 different issues: the case of LA-A213 and my involvement
16 with the Angell Road Children's Home. I shall deal with
17 the case of LA-A213 first. The documents previously
18 provided to me by the inquiry and the questions I was
19 asked to consider prior to giving oral evidence related
20 to alleged sexual abuse of children with learning
21 difficulties in or around 1985. I was asked in oral
22 evidence whether I had experience prior to 1985 of
23 dealing with sexual abuse complaints involving children
24 without learning difficulties. I was asked on the spot
25 to recall events that occurred 35 years or more ago.

1 I responded honestly that I can't recall but I think the
2 answer is no. I think this was the first case.
3 "The independent inquiry, IICSA, has now provided me
4 with various documentation relating to the complaint
5 raised by LA-A213 ..."
6 And that's as I just summarised chair:
7 "... in 1979, some 41 years ago. I did not recall
8 this case when giving my oral evidence to the inquiry.
9 I have now read the documents provided but I still have
10 no recollection of LA-A213 or this complaint.
11 "In respect of the Angell Road questions, I can
12 confirm that the photograph ..."
13 That was a photograph provided by the inquiry:
14 "... I cannot confirm whether the photograph was
15 taken at Angell Road or not. However, since I am
16 wearing non-work clothes, it may well have been taken
17 during my weekend visit to Angell Road.
18 "In the post Shirley Oaks era, we wished to
19 highlight the importance of the children's residential
20 services in Lambeth. In order to better understand what
21 life in a children's home was like and whether there
22 were things that could be done to improve the service,
23 the children's home management group arranged for me to
24 go and stay in a children's home for a weekend.
25 Angell Road was selected by the children's home

1 management group as it was considered to be a good
2 example of a new family group home.
3 "The weekend visit to Angell Road was an official
4 visit and the visit was supported by both the children's
5 home management group and by NALGO. This was,
6 I believe, the first time I had visited Angell Road and
7 was, to the best of my recollection, the first time
8 I had met John Carroll, who was, at that time, the
9 officer-in-charge of the Angell Road Home.
10 "I would have been dressed casually during this
11 weekend stay but I was very much there in my official
12 capacity. Whilst I may have been shown John Carroll's
13 living quarters, I have no specific recollection of
14 going to his flat.
15 "I stayed in a room which I presumed was one of
16 the rooms used to accommodate staff for overnight
17 duties. I do not specifically recall any further visits
18 to Angell Road, although there may have been some as
19 part of my role.
20 "I did not know John Carroll outside of
21 the professional context. As set out above, I do not
22 believe I had met him prior to the weekend stay I had at
23 the home. I believe the facts stated in this witness
24 statement are true."
25 It is signed and dated 22 July 2020-

1 Chair, that concludes what I would ask to be read in
2 today. We have finished a little bit early, but could
3 I suggest we return at the normal time of 13:45?
4 THE CHAIR: Yes, we will do that. Thank you very much.
5 (12.31 pm)
6 (The short adjournment)
7 (1.45 pm)
8 THE CHAIR: Good afternoon, everyone. Ms Langdale?
9 MS LANGDALE: Thank you, chair. May I please call
10 Dr Steele?
11 DR ALISON STEELE (affirmed)
12 Examination by MS LANGDALE
13 MS LANGDALE: Can you give us your name and qualifications,
14 please?
15 **A. Yes. My name is Dr Alison Steele and I'm a member of**
16 **the Royal College of Paediatrics and Child Health and**
17 **I also have a diploma in forensic medicine and**
18 **bioethics.**
19 Q. Dr Steele, you have helpfully prepared a statement for
20 the inquiry in your role as officer for child protection
21 for the Royal College of Paediatrics and Child Health
22 dated 17 March 2020?
23 **A. I have.**
24 Q. Can you confirm for us, please, that the contents are
25 true and accurate, as far as you're concerned?

1 **A. The contents are true and accurate. Just to say that**
2 **I have changed roles at Great Ormond Street Hospital, so**
3 **I'm no longer their named doctor but I was at the point**
4 **I wrote the statement.**
5 Q. At the point you wrote the statement, you were named
6 doctor for safeguarding, as you say, at
7 Great Ormond Street Hospital?
8 **A. I was, yes.**
9 Q. Can you tell us what the role of doctor for safeguarding
10 entails, not just within Great Ormond Street, but
11 generally. What are the extra obligations?
12 **A. You're expected to be a safeguarding specialist within**
13 **a hospital or provider organisation. You would have had**
14 **additional training and experience. The roles are**
15 **actually -- the role is actually set out both in the**
16 **intercollegiate document and in your job description.**
17 **You're responsible, really, for overseeing training, for**
18 **overseeing sort of clinical governance, for overseeing**
19 **systems within the organisation to ensure that children**
20 **and safeguarding concerns are correctly addressed, and**
21 **you actually have quite a lot to do with case**
22 **management, individual case management.**
23 **You work not alone, but with a named nurse, with**
24 **a named midwife if your organisation has a maternity**
25 **unit, and with named safeguarding nurses. So it is**

1 **a team of people that ensure that the hospital does the**
2 **correct thing in relation to safeguarding children.**
3 Q. So where other staff within a hospital have safeguarding
4 concerns, are you seen -- you and the supportive team,
5 the nurse, the midwife, et cetera -- as the people who
6 should be consulted about any particular case or child?
7 **A. We usually would be. I mean, of course, out of hours,**
8 **we would expect staff to be appropriately trained to**
9 **make referrals, you know, immediately, if necessary.**
10 **But, generally, yes, we would be the go-to team to**
11 **advise, support, supervise, and most trusts have**
12 **a system whereby there would be a referral into our**
13 **team, or into the safeguarding team, when there are any**
14 **concerns about a child, to discuss that with the**
15 **clinical team and to make sure things were taken forward**
16 **appropriately.**
17 Q. As you said earlier at paragraph 3 of your statement, in
18 addition to your paediatric training, you have completed
19 a diploma in forensic medicine and bioethics in 2006
20 and, by virtue of that qualification, became a member of
21 the Faculty of Forensic and Legal Medicine.
22 Can you help us with, please, the issue of overlap
23 between the Faculty of Forensic and Legal Medicine and
24 the Royal College of Paediatrics and Child Health?
25 **A. The overlap generally is around issues around assessment**

1 **and treatment of children that have been potentially**
2 **sexually abused. There is some overlap potentially in**
3 **physical injury as well. But, essentially, the -- there**
4 **are sort of two streams to this. So in terms of**
5 **clinicians who are dealing with the assessment of**
6 **children who have been sexually abused and doing**
7 **assessments, they either come from a paediatric training**
8 **background, and would normally be paediatric**
9 **consultants, or they come from a forensic physician**
10 **background, and they will often be GPs or obstetricians,**
11 **gynaecologists, who are a member of their own**
12 **Royal College but, in addition, are a member of this**
13 **faculty.**
14 Q. So around standards, process and policy, the two
15 organisations liaise, don't they, for service
16 specification and clinical evaluation?
17 **A. Yes, we do. We have a really close working**
18 **relationship. It probably wasn't always that way**
19 **historically, but it is now, and so we actually have**
20 **representatives on each other's committees, we meet**
21 **regularly, we have working parties together and we**
22 **produce joint guidance.**
23 Q. Would people at the level you are, as a named doctor for
24 safeguarding at one point at Great Ormond Street, would
25 people in those positions occupy a role within both

1 organisations and have conducted some forensic training
2 as well or not? Is that not a prerequisite?
3 **A. Not necessarily. I think that it tends to be the**
4 **paediatricians who are involved in an assessment of**
5 **children who may have been sexually abused that are also**
6 **linking into the forensic world and the Faculty of**
7 **Forensic and Legal Medicine.**
8 Q. So as far as this inquiry is concerned and our remit, it
9 would be the area where you'd expect those involved to
10 be concerned with both the forensic aspect --
11 **A. Yes. We work very collaboratively.**
12 Q. You were asked for, and very helpfully provided, as much
13 information as you could in relation to how medical
14 examinations were dealt with over an extensive period of
15 time. I think you said between 1963 and 1988, it was
16 very difficult for you to get access to that material
17 because of a change in the organisation that you are
18 now -- have the role of child protection for.
19 Can I just ask you, in relation to that early period
20 to do the best you can from knowing what was happening
21 on the ground and generally. In the '70s, if we can
22 cast our minds back that far, and moving into the '80s,
23 but certainly for the '70s for now for one issue that's
24 arisen for one of our core participants, in the '70s,
25 she thinks she may have been examined under a general

1 anaesthetic in circumstances where she was distressed,
2 so an examination of a child under a general anaesthetic
3 for a child -- let me ask you this: were general
4 anaesthetics used in that decade and into the '80s where
5 there was suspected sexual abuse?
6 **A. I have to be quite honest and say I don't know.**
7 **I certainly have almost never needed to use a general**
8 **anaesthetic, unless a child or young person has an**
9 **injury that requires them to go under anaesthetic and**
10 **have an operative repair.**
11 Q. So if child sexual abuse was suspected, even if a child
12 was in extreme distress, would that be used or not?
13 **A. No. Certainly not currently, and certainly not during**
14 **my career. And I started working in this field in 1993**
15 **as a forensic and medical examiner.**
16 **The only time I would have considered using**
17 **a general anaesthetic was if there was a medical need to**
18 **do so. So say somebody was bleeding torrentially**
19 **following potential sexual assault and they needed to go**
20 **to theatre to have a tear, or what have you, repaired,**
21 **then I might go to theatre as well to obtain forensic**
22 **samples with appropriate consent, but the reason that**
23 **I was going to theatre, or the child was going to**
24 **theatre, wasn't for the forensic side of things, but was**
25 **for their health needs.**

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Q. Would the results of any examination be recorded carefully?

A. As far back as I can remember, yes, because, actually, it is part of good medical practice. So it doesn't just relate to forensic medical examinations, it relates to all areas of medical practice, and certainly since I qualified in 1985, it always has done.

Q. Are they ever video recorded?

A. So the examinations are video recorded now, with appropriate consent. But certainly when I started practice in 1993, that wasn't the practice and we didn't have the equipment to do so.

Q. Going back to the '90s, the inquiry has heard evidence about a girl whose behaviour, once moved from foster placement, indicated she may have been sexually abused there and she underwent a medical examination, and the report was completed by a community medical officer rather than a paediatrician, and was described as inconclusive. The child underwent a subsequent psychiatric assessment, concluding that she'd likely been sexually abused. So a number of questions growing from that.

Community medical officer. Is that what you would expect into the '90s, conducting a physical examination?

A. A community medical officer probably is a paediatrician,

but not one that's training to be a consultant or is a consultant. So it's quite likely that a community medical officer was practising within paediatrics. Sorry, what were the other questions?

Q. Would you expect -- that was the only question, thank you, you have answered that question. Would you expect the examining doctor to have access to full historical medical records before conducting that investigation, even in the '90s?

A. Not necessarily, because we don't have a single medical record for -- even now, for the whole of a child or young person. The GP keeps the most complete medical record. What we would do is, if I was working in a particular hospital, then -- if there was time to get the medical record, I would get the medical record, but often children come in from different areas, so you might not have a complete picture in that medical record, and obviously, if it was, you know, 10.00 o'clock at night, you would endeavour to get what medical records there were, but you might need to go ahead with an assessment without a medical record at that time. But what you would do is endeavour to get what medical records you could as soon after the examination as was possible.

Q. Would you, for older children now, try and get from them

a story or not about why they were there, or would you not --

A. So this is difficult. I would be quite careful what I said, because they probably -- it depends on the situation, actually, to be quite honest with you, whether it's a recent assault or a non-recent assault. If it is a recent assault, they probably haven't had their achieving best evidence interview yet, so I want to be really clear that I don't undermine that in any way.

And they will also have given an account to police or -- usually a police officer. So what I will do is, I will take the account that they have given to the police officer and then I will talk to them to say that we don't need go through everything in detail because I have that account that they told the police officer, but there may well be some additional questions that I need to ask them to address what are their health needs and where I need to take forensic swabs from. So I will ask limited questions, and I will do that and I will record the answers verbatim. I would, of course, respond to a child or young person if they wanted to discuss something with me. I wouldn't say, "No, I can't discuss that", because that's not what they need in that period. They need someone responsive. So if a child or

young person made a comment, I would follow that up and I would make sure I recorded the conversation.

Q. You say at paragraph 9 of your statement that, whilst you're able to provide a response on the development of national policy between 1988 and present day, it's likely practice varied according to local need, resource and interest. Some of this variation will have complied with the demands of national policy. However, we would speculate that it is likely that some services were not meeting the required standards.

Can you elaborate upon that?

A. I think -- so, basically, the Royal College of Paediatrics and Child Health and the FFLM, we can only set standards. We don't commission services, and never have done, and we can't enforce. We are not an inspectorate or a regulator in any way. So we can set standards and we can then promote them and we can alert commissioners and regulators to them.

So I think it is quite difficult. We can set these standards, but I think anecdotally there's been -- there was concern that, actually, the standards weren't being uniformly complied with, but it's difficult to have concrete evidence around that.

Q. Indeed, at paragraph 47, if you go to that in your statement, you refer to the 2015 service specification

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1 describing how variation in commissioning is likely to
2 result in variation in service delivery and the ability
3 to measure and compare outcomes across the UK. You say
4 there, as you said now, that the RCPCH is working with
5 other partners to address quality standards and
6 variation in service delivery. Is that about commitment
7 to this issue, commitment of examinations of children
8 and providing the best possible circumstances for them?
9 Why do you see that local variation?
10 **A. I think some of it may be appropriate because it might**
11 **depend on whether you're an urban centre or a very rural**
12 **centre and what you might be able to provide. I think**
13 **that there is commitment to it, but sometimes the**
14 **resources don't follow that, and in particular I think**
15 **there's always been concern about having enough**
16 **qualified, experienced medical examiners for children.**
17 Q. You say the RCPCH can only set standards but can't
18 enforce them. Of course, doctors, themselves, have
19 literature, don't they, via the General Medical Council
20 about protecting children and young people and their
21 obligations?
22 **A. Absolutely, yes.**
23 Q. So if there are issues around individual doctors,
24 reporting requirements may be triggered or concerns may
25 be triggered in that context?

1 **A. So I think there would be two ways of addressing**
2 **concerns about the practice of individual doctors. One**
3 **would be through their employers and disciplinary**
4 **processes, and that is then linked to the**
5 **General Medical Council because employers would refer to**
6 **the General Medical Council if they were concerned, who**
7 **are the professional regulators. But also anybody else**
8 **could refer a doctor to the General Medical Council, so**
9 **a police officer could, a social worker could, and**
10 **there's very strict sort of guidance from the**
11 **General Medical Council about the duties of doctors**
12 **pertaining to child protection.**
13 Q. In terms of outcomes from examinations of children
14 suspected of having been subject to child sexual abuse,
15 at paragraph 48 you say outcomes can be measured in
16 different ways. Can you expand upon that paragraph for
17 us, please?
18 **A. Yes, because, actually, for me, the most important**
19 **outcome is that they heal, that they -- both physically,**
20 **mentally and emotionally, and, actually, that's**
21 **a difficult outcome to measure. People tend to measure**
22 **outcomes in terms of either child protection outcomes or**
23 **criminal court outcomes. So those are easier outcomes**
24 **to measure, and they are important outcomes, but**
25 **actually it's about -- to me, the most important outcome**

1 **is the welfare and well-being of the child or young**
2 **person, and that's a much more difficult outcome to**
3 **actually measure.**
4 Q. So, as you address -- and we are going on to look at the
5 2019 guidance in this area -- it is not simply whether
6 information is useful for a prosecution, if I can put it
7 in that way, and frequently, we know, inconclusive, to
8 use that phrase, it is often inconclusive in terms of
9 a prosecution of a particular offender, isn't it?
10 **A. So most examinations probably don't provide**
11 **corroborative evidence. That doesn't mean to say that**
12 **that process isn't a helpful process, because, actually,**
13 **there are two things that are going on within that**
14 **assessment or examination. One thing is addressing the**
15 **health and well-being of that child or young person,**
16 **both in terms of the actual assault -- you know, it**
17 **might be STI, it might be screening, it might be**
18 **post-coital contraception, it might be giving HIV**
19 **prophylaxis. It is then picking up unmet health needs**
20 **of which there are often quite a lot. So there is that**
21 **side of it and at the same time you are potentially**
22 **gathering forensic evidence for safeguarding and**
23 **criminal processes. So it is a dual thing -- it is**
24 **a dual-purpose assessment.**
25 Q. Can we look, then, and can I ask, Mr Hyde, if we can

1 have on the screen, please, RPC000022_001 and 005.
2 Dr Steele, this is the Centre of Expertise on Child
3 Sexual Abuse, "The Role and Scope of Medical
4 Examinations when there are Concerns about Child Sexual
5 Abuse: A Scoping Review", which you referred our
6 attention to.
7 If we look at page 5 -- so the first page can go
8 down now and just have page 5. We see there the
9 summary, Dr Steele:
10 "This report aims to help professionals involved in
11 advising and referring children, young people and
12 families so that they better understand the role and
13 purpose of a medical examination in situations where
14 child sexual abuse has been disclosed or is suspected.
15 "It presents evidence of the likelihood that medical
16 examinations can:
17 "Obtain evidence of CSA ... or other categories of
18 abuse.
19 "Benefit health and well-being more broadly, such as
20 by identifying sexually transmitted infections, blood
21 borne infections ..." et cetera.
22 We see the report is expressed to be of interest to
23 front-line practitioners in social care, police and
24 health, particularly those who engage with children and
25 young people, prior to a possible referral for medical

examination and to leaders and those responsible for the professional development and education of professionals in these sectors.

We see "Key messages" there. Firstly, and we can leave it on the screen so people can read it as you give your evidence, Dr Steele, but most children are not referred for medical examination. What is the available evidence from this document around that?

A. **There are some figures later on in the document that would suggest that only about a quarter, roughly, of children are referred for medical assessment, but I can't give you the exact page, but certainly later on in that document -- because this is a document that tries to gather evidence about these issues.**

Q. Yes. I will go to the details. But, broadly, the concern is that children aren't being referred when perhaps they should be; is that the point?

A. **I think I've always had a concern that that may be the case, and certainly as paediatricians in this area, both named and designated doctors, we spend some -- a considerable amount of time trying to explain the reason that we would like to see children for medical assessment to the police and social care and to other medical practitioners.**

I think the feeling is that if there isn't anything

likely to be found that will be helped to corroborate investigations, both social care and police, then children shouldn't be, and I quote, "put through a medical examination". But actually, obviously, from this document, it can actually be quite a positive experience if it is done properly, if children are prepared, they're re-empowered, they're given choices, they have got questions they might want to ask about their body, about what's happened to them. So I actually think it is actually -- not for all children, but I would hope that it would be a more positive thing for most children and it gives them the opportunity to discuss things that maybe they haven't been able to discuss with people who aren't doctors or health professionals.

Q. We see:

"The view that medical examinations for CSA are themselves harmful for children is not well supported by the limited available evidence of children's experience. More research is needed, particularly in the UK, but the existing evidence indicates that most children exhibit a level of fear in line with that felt about other types of medical examination, and this fear diminishes over the course of the examination."

It moves on to say:

"Most children reflect on the medical examination as a positive experience."

But:

"... depends on the clarity of information and advice they receive before the examination ..."

If we go to page 29 of the document, we will see there, Dr Steele, views of children and their carers. Can we enlarge that, please? That would be helpful.

So we see at paragraph 7.1 "Expectations". The perception, if we can go to the last paragraph of "Expectations":

"There may be a perception among some young people that a medical examination will strengthen evidence."

It sets out the position as you described earlier, that that is not always going to be the case. If we go over the page, please, to page 30 and page 31 on the screen, we see paragraph 2 on page 31:

"Research in Australia found 9 out of 53 carers did not know or were unsure of what the examination entailed. This knowledge deficit was associated with significant levels of parental stress before the medical examination, but seemed to be associated with their children being less likely to be scared during the medical examination. The authors of the study questioned whether this raised issues about the timing

and content of the information provided, including its accuracy ..."

What are the issues around parents and others knowing how the medical examination is going to be conducted?

A. **I personally think it is quite important that both parents and children and young people know what is going to happen to them, and there are some centres which actually have material on YouTube, and those are the places that actually talk children through what will happen to them when they come to the centre.**

I mean, personally, when I've seen children and young people in the past, the first thing I have to say to them is that I will explain everything and nothing is going to happen to them without them understanding why and being given choices about it. And I think if you say that at the very start of the assessment, you can actually see the sort of relief, you know, you see the sort of -- I mean, obviously it is still a very difficult assessment, but what we mustn't do is re-traumatise or re-abuse children by the assessments, and, therefore, we have to empower them again to be able to make choices about their bodies, but explain to them what we are doing and why, and, actually, if the child says that they don't want to be examined, we absolutely

1 **respect that, and we will try and deal with the health**
2 **issues alone.**
3 Q. Indeed, in the page that's been taken down -- we don't
4 need it -- there is reference to pain and discomfort.
5 Several studies explored whether the examination was
6 felt to be painful. The results were variable and many
7 factors needed to be considered in their interpretation.
8 If we can have, Mr Hyde, please, page 33 on the screen,
9 pages 32 and 33, actually. It is very helpful to see it
10 as it is expressed through the report. "Mitigating
11 factors" for the child in terms of the examination. We
12 see there, Dr Steele, "Clinician behaviour and
13 expertise". It seems an obvious one, but that is going
14 to make a difference?
15 **A. Extremely important, actually.**
16 Q. If we look at implications for practice, which is
17 helpfully on the -- it's already been highlighted within
18 the document, but if you look at page 33:
19 "Children and carers should be prepared in advance
20 of a medical examination. The professional doing this,
21 whether health based or not, must be well informed and
22 accurate."
23 **A. Absolutely. I mean, I'd like them to be informed before**
24 **they come for a medical examination, but, actually,**
25 **I would spend maybe 15 minutes, 20 minutes, taking**

1 **consent for an assessment of that nature, explaining**
2 **absolutely everything and the options and what we can**
3 **choose to do or not do. So, actually, having that**
4 **information is really, really important, and, you know,**
5 **you won't actually be able to achieve a very successful**
6 **examination, you can't force children to be examined,**
7 **they have to understand why they're being examined, what**
8 **the consequences may be, that potentially it may be**
9 **uncomfortable or even hurt -- it depends whether they**
10 **have any injuries or not. But I think the really**
11 **important thing is to be honest and upfront with**
12 **children and young people, and with the carers that**
13 **bring them.**
14 Q. How does that work with very young children? I mean,
15 the inquiry has been hearing about children as young as
16 3, 4, 5, having --
17 **A. I think -- so this is where your experience and judgment**
18 **comes in, you know, of dealing with children generally.**
19 **So you'd want to explain in an age-appropriate,**
20 **developmentally-appropriate way. So for children at**
21 **possibly 3, 4 above would have to, I would say, assent**
22 **to the examination. So it isn't that they're legally**
23 **consenting, because they don't understand all aspects of**
24 **it, but you're explaining to them in a way that they can**
25 **understand and that they agree to. I think it is a bit**

1 **different when you're talking about a child that's**
2 **a year or 18 months, obviously, because they don't have**
3 **the language, they don't have the understanding, and,**
4 **actually, to be quite honest, they're happier about you**
5 **looking at their bottom than they are looking in their**
6 **ears. So it just depends, I think, on the**
7 **circumstances, and you have to give some rationale to**
8 **any child why you're doing something, and you're going**
9 **to tailor that to, as I say, their age, their**
10 **development, the situation that you find yourself in.**
11 **That's where having experienced examiners is really**
12 **important.**
13 Q. Again, in the guidance it states:
14 "Clinicians undertaking medical examinations should
15 be mindful that their behaviours can affect the
16 experience of a child both positively and negatively."
17 Is there work from the RCPCH surrounding training
18 and understanding what that means, the implications for
19 children and clinicians?
20 **A. I mean, there's training generally. So in our training**
21 **syllabus -- so we have the remit to set the training**
22 **curriculum until people become consultants and then we**
23 **support them thereafter. But, actually, things like**
24 **communication with children are very important in the**
25 **curriculum, and would be measured at annual reviews of**

1 **trainees' progression, career progression.**
2 Q. Now, the sample sizes within this study are small,
3 aren't they, when we see it, when we go through the
4 details? I don't need to take you to it but they're not
5 huge figures. The conclusion is suggested to be:
6 "Medical examinations have a valuable place in the
7 holistic assessment of abused children's health and
8 well-being."
9 **A. Yes, that's certainly what Michelle Cutland's report**
10 **suggests. She does call for more research into this.**
11 **It would certainly be my clinical experience that, on**
12 **the whole, the feedback that I have had from children**
13 **and young people is that, actually, although they have**
14 **been frightened, it's been difficult, it can be**
15 **embarrassing, but actually they -- I don't want to say**
16 **it's positive, because obviously nobody wants to be**
17 **there, but actually we have been able to address the**
18 **issues that need addressing, we have been able to answer**
19 **questions, and I think they do sometimes feel quite**
20 **relieved, or they should do as they leave.**
21 Q. If we can have from the same document page 43, so,
22 Mr Hyde, it's RPC000022_043. In terms of barriers, if
23 I can call it that, to medical examinations and
24 practitioners' concerns, if we can highlight on the
25 table at the top, please, Mr Hyde, these are

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1 practitioners' concerns, aren't they, in thinking about
2 whether there should be referral for medical
3 examination? We see there the intrusive nature of it.
4 That's a starting point, generally, for this type of
5 examination, isn't it? In terms of how they have been
6 modernised, are examinations as intrusive as they were,
7 in terms of how swabs are obtained and --
8 **A. Well, for younger children, we wouldn't take any**
9 **internal swabs anyway. We are actually taking external**
10 **swabs and looking. Therefore, what I would say for**
11 **younger children, it's more about keeping still during**
12 **the examination rather than it physically hurting them.**
13 **Obviously, it can mentally hurt them. You know,**
14 **they can be emotionally disturbed by it. But I think**
15 **they're less likely to be if you explain what you're**
16 **doing and why.**
17 **Also, stop. So you stop the examination if you feel**
18 **that the child is getting -- is becoming too upset.**
19 **With older -- you know, with young people,**
20 **adolescents' age, they might even say, "Oh, it's**
21 **hurting", and I'll say, "I'll stop", and they say, "No,**
22 **I want you to go on". So you're having that**
23 **conversation with them and making sure they are in**
24 **control. Of course it is intrusive, because it is**
25 **intrusive to their bodies and these children and young**

1 **people have been potentially sexually assaulted or**
2 **abused, so it is intrusive, but that doesn't mean to say**
3 **that that cannot be managed in a way that we can**
4 **actually have positives that outweigh the negatives.**
5 Q. It rather suggests, doesn't it, these potential
6 barriers, that there needs to be good communication on
7 the ground between local areas and partnerships between
8 those referring children, having trust in those they
9 refer to for such examinations; police, social care also
10 being involved at a multi-agency level where child
11 sexual abuse is suspected and an examination is
12 indicated?
13 **A. Absolutely, and paediatricians will go out and train**
14 **social workers and police officers about their role and**
15 **the nature of examinations, and we continue to do so,**
16 **but there's obviously a turnover in staff so you need**
17 **to -- you can keep on with that message.**
18 Q. Of course, in the period from which the inquiry begins
19 its examination, examinations, physical examinations,
20 were occurring at police stations?
21 **A. That's my understanding. It's never -- in my experience**
22 **from 1993 onwards, that wasn't occurring. I was never**
23 **aware of that occurring. But I understand that it did**
24 **occur.**
25 Q. Can I ask us now, please, to have a look briefly at

1 RPC000006_001. It's the RCPCH service specification for
2 the clinical evaluation of children and young people who
3 may have been sexually abused. Can we please look at
4 page 9 of this document, quality standards. So this
5 document, Dr Steele, is outlining standards for the
6 provision of a paediatric forensic medical service for
7 children and young people, prepared by the RCPCH, to set
8 standards. We see there agreed quality standards. As
9 you have indicated, no way of being sure that they are
10 implemented through the regions, but set out quality
11 standards around the service that should be provided.
12 Can you deal with bullet point 4 for us:
13 "A suitable physical space, waiting area, age
14 appropriate toys ..." and so forth.
15 Where, now, would you expect, as part of best
16 practice, this kind of investigation or examination to
17 take place?
18 **A. So I think -- so either in a paediatric SARC or in a --**
19 Q. Sorry, can I ask you not to use acronyms there?
20 **A. Sorry, Sexual Abuse Referral Centre for children,**
21 **specifically designed for children.**
22 Q. Yes.
23 **A. Or, if there wasn't any need to take forensic swabs or**
24 **samples, so there wasn't any issue with contamination or**
25 **cross-contamination, it could either happen there or it**

1 **could happen in a suitable community paediatric seating.**
2 Q. Two bullet points below, the high quality photo
3 documentation. In terms of record keeping, former
4 children in care, the records of examination or
5 information around their histories, the paucity of
6 records is obviously upsetting or a matter of concern.
7 What now is required?
8 **A. There's usually a pro forma, which actually guides**
9 **people through that. It is pages and pages of records**
10 **that are taken in a structured form. It probably -- in**
11 **terms of the assessments, particularly if there are**
12 **forensic samples, I would say you're talking two or**
13 **three hours of assessment and a lot of that is writing**
14 **in a pro forma, and then obviously there would be --**
15 **with consent, there would be photo documentation or**
16 **video imaging of the examination.**
17 Q. If we can have page 10, the next page, please -- sorry,
18 page 9 of the document, page 10 inquiry reference
19 number, but the next page of the document, at
20 paragraph 2.13. It also sets out there:
21 "... good practice that:
22 "All acute cases have a crisis worker."
23 What's the role of the crisis worker?
24 **A. To support the child or young people.**
25 Q. "All children, whether their case is acute or historic,

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1 going through the criminal justice process, should be
2 offered access to a child advocate ... to support
3 themselves and their families."
4 A. **Yes.**
5 Q. And:
6 "Children's social care should be involved at an
7 early stage. Normal practice should be, at a minimum,
8 a strategy discussion between children's social care,
9 the police and the paediatrician ...", et cetera.
10 Again, whether this is happening on the ground is
11 another issue?
12 A. **These are the standards we set for 2015. We will need**
13 **to be reviewing this document in the fairly near future,**
14 **because I think there are still -- we have always got**
15 **things to learn and there are -- as in calling some**
16 **abuse historic. I think there's more that we can put in**
17 **about preparation before assessments and examination.**
18 **So, yes, it's important, but these were the quality**
19 **standards that were set then.**
20 Q. You anticipated my next question. When is the next
21 update, do you think, from the 2015?
22 A. **Well, we have to do some work on what we call the**
23 **competency matrix between ourselves and the FFLM and the**
24 **Royal College of Nursing, because there are now nurses**
25 **examining children for sexual abuse in some areas. So**

1 **once we have done the competency matrix, we are then**
2 **planning to rewrite the service specification and to**
3 **take that into account.**
4 Q. Finally, on acute cases, the guidance -- we don't need
5 the guidance before you for these purposes, but it is
6 envisaged, in acute forensic assessment cases,
7 specialist medical advice should be sought within one
8 hour of a complaint or an allegation being made from
9 a doctor with paediatric sexual offences medicine
10 competencies. So different preplanning circumstances?
11 A. **You have to move more quickly if the assault is recent.**
12 **Often there will have been a strategy discussion. It**
13 **may not have included the paediatrician, although it**
14 **should do. But that, actually, they will -- someone**
15 **will ring you, usually a police officer in a case of an**
16 **acute assault, and I would take a number of details and**
17 **ask a number of questions. First and foremost,**
18 **ascertaining whether the child needs immediate medical**
19 **attention and needs to go to hospital somewhere**
20 **directly, and then, secondly, ascertaining a number of**
21 **other aspects, including who is going to come with the**
22 **child and support them and who can consent for the**
23 **process.**
24 Q. Finally, then, Dr Steele, whilst, obviously, you don't
25 know how this is being implemented in various regions or

1 at different times of the day and night in different
2 centres, but the reality is, from a guidance
3 perspective, you're satisfied that the RCPCH has set out
4 the developments in thinking and what's required to
5 effect best practice for examinations, holistic
6 assessment of children's needs?
7 A. **Yes, and I think, as with all guidance, it evolves, and**
8 **certainly we are always learning, so, yes, that was the**
9 **guidance that we wrote in 2015 and we are planning to**
10 **look at what we have learnt in the last five years and**
11 **incorporate that in the next set of guidance.**
12 MS LANGDALE: Thank you. There are no further questions
13 from me, Dr Steele. I don't know if there is from the
14 chair and panel.
15 THE CHAIR: Thank you. I have no questions, but I will ask
16 my colleagues if they have any questions. Ms Sharpling?
17 MS SHARPLING: No, thank you, chair.
18 THE CHAIR: Mr Frank?
19 MR FRANK: No, thank you.
20 THE CHAIR: Sir Malcolm?
21 PROF SIR MALCOLM EVANS: No, thank you, chair.
22 THE CHAIR: Thank you very much, Dr Steele.
23 A. **Thank you.**
24 **(The witness withdrew)**
25 MS LANGDALE: Chair, may I suggest we resume at 2.45? We

1 are slightly ahead of our schedule, but that would be
2 a good time, perhaps.
3 THE CHAIR: Yes, we will do that. Thank you.
4 (2.22 pm)
5 (A short break)
6 (2.45 pm)
7 MS LANGDALE: May I call, please, Emma Harewood.
8 Ms Harewood, it may help to say something so you appear
9 on the screen now.
10 MS EMMA HAREWOOD (sworn)
11 Examination by MS LANGDALE
12 MS LANGDALE: Can you give us your name, please?
13 A. **Yes. My name is Emma Harewood.**
14 Q. Ms Harewood, you have prepared two statements for us as
15 The Lighthouse development and service manager at
16 University College London Hospitals NHS Foundation
17 Trust, and your statements are dated 18 February 2020
18 and yesterday, 27/7/2020, a short additional statement.
19 A. **That's correct.**
20 Q. You, as you set out in those statements, respond to the
21 inquiry in your capacity as development and service
22 manager, and you tell us at paragraph 1.2 of your first
23 statement you have led the transformation of child
24 sexual abuse services across London, leading to the
25 development of the CYP Havens Service, Child Sexual

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1 Abuse Hubs and the first UK pilot of the Child House
2 model?
3 **A. That's right.**
4 Q. Before we go into what those models or the model is, can
5 I suggest that we go to the pathway piece of research
6 that you and two others co-authored in 2015 to set the
7 theme, as it were?
8 **A. Yes.**
9 Q. Can I ask, Mr Hyde, please, if we can have INQ005455_001
10 and _004 on the screen together, please. This is your
11 research, Ms Harewood, that was commissioned by
12 NHS England, and we see at page 4 the executive summary.
13 We see, Ms Harewood:
14 "Children and young people who have been sexually
15 assaulted or abused need medical care and support. At
16 present, very few of them come to the attention of
17 police, social care or health providers, and even fewer
18 in the period soon after the abuse. It is thought that
19 children and young people face a variety of obstacles in
20 accessing care and support and that services and
21 accessibility vary widely across London. This review
22 sought to assess the service provision across London in
23 order to better understand some of these obstacles. It
24 explored national recommendations, international
25 agreements, research and models of best practice for

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1 children who have been sexually assaulted. Based on the
2 review findings, we have made recommendations aimed at
3 improving the care and support ..."
4 You refer in paragraph 2 to the team interviewing
5 nearly 200 stakeholders involved in the care of children
6 and young people who have been sexually assaulted and
7 reviewed available data from The Havens. Where were the
8 stakeholders coming from, as a range?
9 **A. They came across all the 32 London boroughs. They came**
10 **from a mixture of places -- some of them were**
11 **commissioners from Clinical Commissioning Groups, some**
12 **were from local authorities, some were paediatricians,**
13 **named doctors or designated doctors, as Dr Steele**
14 **described earlier, some worked in the voluntary sector,**
15 **some worked in Child and Adolescent Mental Health**
16 **Services, or CAMHS as we refer to them. And some were**
17 **from the police.**
18 Q. You say within that summary:
19 "On average, 400 children and young people attend
20 The Havens ..."
21 Just to be clear, The Havens is relevant to Lambeth
22 children, isn't it?
23 **A. Yes, it is a pan-London service.**
24 Q. "On average, 400 children and young people attend
25 The Havens each year for a forensic medical examination

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1 following an acute sexual assault. This number probably
2 represents less than 5 per cent of the children and
3 young people living in London who have experienced
4 contact sexual abuse in the past year and suggests there
5 is a significant unmet need."
6 How did you arrive at those figures?
7 **A. You will see in the paragraph below we use an NSPCC**
8 **study which had interviewed a number of children and had**
9 **asked whether they had experienced sexual abuse in the**
10 **last year or ever, and so we used that 1.9 per cent**
11 **number of children that had experienced contact sexual**
12 **abuse in the last year and took 1.9 per cent of**
13 **the child population of London and that brought us to**
14 **that number of 12,000, and if my maths is correct --**
15 **maybe that's not quite my correct maths. Anyway, that**
16 **was the number we used. We took the number of children**
17 **we anticipated would have been sexually abused and used**
18 **that as a comparison with the 400.**
19 Q. We see on page 5 of the report, INQ005455_005, please.
20 Under "The Havens" what did you find, as at 2015, in
21 that first paragraph, were the limitations on the
22 environment that The Havens was providing?
23 **A. The Havens, at that time, was designed predominantly for**
24 **adults or for children aged 13-plus. So it was quite**
25 **a clinical environment and, in some cases, quite an**

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1 **austere environment for children. It was designed**
2 **primarily to collect forensic DNA evidence and, for that**
3 **reason, it needed to be very easily decontaminated.**
4 **Therefore, not only was it slightly out-of-date rooms**
5 **and environment, but it was very clinical -- lots of**
6 **plastic, wipedown furniture, nothing on the walls.**
7 **Quite a frightening place, I think, for a young child to**
8 **go to.**
9 Q. Can we have page 6, please, Mr Hyde? You record on
10 page 6:
11 "Emotional support following CSA was found to be
12 lacking."
13 Can you expand on that for us, please?
14 **A. Yes. So whereas in The Havens in London the adults were**
15 **able to access counselling services, children and young**
16 **people at that time, there was no counselling services**
17 **commissioned for those, so the alternative was to refer**
18 **them to their local CAMHS provider, their local Child**
19 **and Adolescent Mental Health Services provider, and the**
20 **difficulty with that is that they often waited six or**
21 **nine months for support or sometimes didn't even meet**
22 **the criteria.**
23 Q. What is the strict tier 3 criteria?
24 **A. So, generally, it varies by -- from provider to**
25 **provider, but it generally requires children to be**

1 **showing and have diagnosed severe and enduring mental**
2 **health conditions, so they would need to have had**
3 **a diagnosed mental health condition that had been**
4 **enduring for some time.**
5 Q. Can we have the whole of page 7 on the screen, Mr Hyde,
6 and leave the whole page showing at the same time as
7 clearly as we can. We see "Research and best practice".
8 You looked at various legal principles and you looked at
9 various other principles, and you conclude at the end of
10 paragraph 1:
11 "At the core, the system should be designed to fit
12 the child rather than force the child to fit the
13 system."
14 Can you expand upon that for us, please?
15 A. **Yes. It felt very much like -- I guess you must**
16 **remember, I was coming at this from a health**
17 **perspective, so I had very little familiarity at that**
18 **point with the justice system. My observation was that,**
19 **in Iceland, they had made a very child-focused justice**
20 **system where the lawyers, defence and prosecution and**
21 **the judge came to the child on their terms in their**
22 **timescale, if you like, and fixed the system so that it**
23 **had minimal impact on the child. Whereas what**
24 **I observed in London was that the children were passed**
25 **from between many services to services to services.**

1 **Now, while each service was doing their absolute best**
2 **within the resources they had available, for the child**
3 **and families we spoke to, it felt like being passed from**
4 **pillar to post, if you like, and they had to fit in with**
5 **the professional systems.**
6 Q. And repeat what they'd been saying to each one on that
7 journey?
8 A. **Yes, that's right.**
9 Q. If you look at paragraph 3 of that page, please, when
10 you give the Iceland example, you set out there the
11 interview is witnessed -- sorry, the interview is
12 witnessed by the child's advocate, social worker, the
13 defence and prosecution teams, with a judge presiding:
14 "The Barnahus is effectively an outreach of
15 the courtroom at that time and the recorded interviews
16 usually suffice as the child's full testimony for court.
17 The interviews are reportedly more successful in
18 obtaining information with increases in the number of
19 prosecutions and convictions for child sexual abuse",
20 et cetera.
21 You set out various themes, as you have just alluded
22 to, that identified in the London review that you
23 conducted. One of them we see at bullet point 5:
24 "There is a sense of 'normalisation' and
25 desensitisation around sexual behaviours and assault

1 among professionals and young people."
2 Can you expand upon that, please?
3 A. **I guess because there was becoming an increased amount**
4 **of sexual behaviour and interactions between children,**
5 **particularly in schools, with a lot of sexting and those**
6 **types of things. This is something that was reported by**
7 **children, but also by professionals, that it felt**
8 **like -- there are lots of occasions, for example, when**
9 **a boy lifts a girl's skirt or a lot of occasions when**
10 **sexts are sent. It felt like it was becoming a bit less**
11 **shocking and more usual. Not that that made it right,**
12 **obviously, but it was becoming a little more**
13 **commonplace.**
14 Q. Can we look at page 8, please, the next page of
15 the document. Flagging up there, overall absence of
16 support for parents and caregivers; lack of service
17 flexibility and choice for patients and families; poor
18 engagement with local borough services. And the list
19 goes on. You set out recommendations. I want to see
20 where you were at, at 2015, at the time of concluding
21 this in March 2015:
22 "First choice and long-term goal: a Children's House
23 (Barnahus) model x 3-5 locations in London."
24 I'm going to come onto the Barnahus model more
25 specifically in a moment:

1 "Second choice: child sexual assault hubs x 5-7
2 locations in London and paediatric haven plus."
3 And then "Team around the worker", et cetera.
4 Again, not detailing The Lighthouse firstly, but
5 what concluded as a consequence of this research and
6 pathway?
7 A. **I think, most unusually, and actually a real credit to**
8 **NHS England, the result of this review was the**
9 **commissioning of a two-year programme called "The Child**
10 **Sexual Abuse Transformation Programme in London" which**
11 **they commissioned. Actually, we then spent the next two**
12 **years delivering on those recommendations. So very**
13 **quickly the Children's Haven Service was funded, and**
14 **that opened within the first year and, again, very**
15 **quickly work began on child sexual abuse hubs in**
16 **a number of the sectors across London. London's split**
17 **geographically into five regions from a health**
18 **perspective.**
19 Q. So The Havens in Lambeth?
20 A. **The Havens is in Denmark Hill, so, yes, Lambeth.**
21 Q. You say in that brief second statement, the London
22 Borough of Lambeth was involved in those discussions and
23 steering groups, was it, at that time?
24 A. **Yes. So the programme had an overarching programme**
25 **board, and then we established a steering group in each**

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1 **of the regions, now known as STPs, transformation**
2 **partnerships, and Lambeth sits in the south-east London**
3 **region, and so Lambeth -- when I say "Lambeth", I mean**
4 **Lambeth -- the whole borough, not necessarily just**
5 **social care. All of the providers in that area were**
6 **part of that south-east London steering group.**
7 Q. You tell us in that brief second statement:
8 "Local health commissioners, including Lambeth
9 Clinical Commissioning Group, funded a small child
10 sexual abuse hub service provided by Safer London
11 starting in 2018 to work alongside local
12 paediatricians."
13 **A. Yes, that's right, they did.**
14 Q. I don't suppose you have more information about that,
15 given your current role, but that was set up in 2018?
16 **A. It was, yes. I did actually speak to the service**
17 **provider yesterday just to check whether that was still**
18 **running, because, obviously, I haven't had any contact**
19 **for a while. She was very pleased to tell me they are**
20 **still continuing to fund it until 2021 at this present**
21 **time, funded until March 2021.**
22 Q. When you say "until March 2021", is that reviewed at
23 that point? It doesn't mean it is an end point, it
24 something that's reviewed?
25 **A. Yes. Usually health commissioning is set for a period**

1 **of one, two or three years. So, yes, they were extended**
2 **after the initial funding. So the practitioners that**
3 **work for Safer London, who are -- come from**
4 **a therapeutic background but also an advocacy**
5 **background, they work very closely with the**
6 **paediatricians in the area, so the paediatricians in**
7 **Lambeth that undertake the examinations will do that**
8 **with the Safer London practitioner together and then the**
9 **Safer London practitioner will offer six to eight**
10 **sessions of emotional support for the child and family.**
11 Q. Where does that arise physically? In one set space? Is
12 it commissioned in a particular space where that work is
13 undertaken, or examination is undertaken, by
14 paediatricians or are they in different places?
15 **A. The examinations take place, my understanding is, in one**
16 **place in Lambeth and, on the day of the examinations,**
17 **which is probably usually, perhaps, once a week, the**
18 **Safer London practitioners join the paediatricians.**
19 **Safer London provide lots of other services in the area,**
20 **so I'm afraid I don't know the exact base of their team.**
21 Q. Can we go to what happened as a consequence of your 2015
22 research. We see the Children's Commissioner published
23 a report in September 2015 arising from that. If we can
24 have on the screen, please, INQ005454_001 and _003. We
25 see the Children's Commissioner in the introduction:

1 "In England, it is estimated that only 1 in 8
2 victims of child sexual abuse are identified by the
3 authorities. Children who disclose that they have been
4 sexually abused face multiple interviews with social
5 workers, the police and medical professionals in
6 a variety of settings. Interviews are often the only
7 source of evidence in sexual abuse cases, yet for many
8 children the interviews led by the police do not enable
9 them to provide the best possible evidence. Repeat
10 interviews can be confusing and cause children,
11 particularly young children, to give inconsistent
12 evidence which, in many cases, will lead to the
13 perpetrator not being charged. Children can be
14 traumatised by having to give an account of their abuse
15 to multiple professionals in multiple locations. They
16 can also then face long waiting lists to access
17 specialist therapeutic support."
18 Then highlighting:
19 "The current system is not child-centred and does
20 not achieve the best results either for the children or
21 the criminal justice system."
22 Then setting out, as you had highlighted, the
23 Barnahus overview and how that placed the child at the
24 centre.
25 If we can, please, have a look at pages 5 and 7 of

1 the report, INQ005454_005, and then missing a page and
2 on to page 7. If we look at 5, first of all,
3 "A home-like setting". What's the context of
4 the home-like setting?
5 **A. So in the Barnahus in Iceland, which was the first**
6 **Barnahus, it is literally in a house at the end of**
7 **a cul-de-sac in a residential area. They have converted**
8 **a house into the place where they undertake**
9 **examinations, provide therapeutic support and do the**
10 **interviews. The children arrive and almost wait in**
11 **a lounge, rather than a traditional waiting room with**
12 **a receptionist.**
13 Q. Then, if we look at the third paragraph down on the same
14 page, in that model in Iceland, the child -- during the
15 exploratory interview, the child is interviewed by
16 a psychotherapist trained in forensic interviewing.
17 Yes?
18 **A. Yes.**
19 Q. If we go to page 7, paragraph 2, here the commission
20 makes reference to:
21 "The criminal justice process is embedded within the
22 Barnahus. The recorded interview serves as testimony
23 for the court with few children under the age of 15
24 being required to give evidence in person. This
25 improves the quality of the evidence available to the

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1 court. Typically, the court case is heard six months
2 following the interview. Given that the investigative
3 interview serves as testimony, there is no question of
4 diminished recall and inconsistency with previous
5 accounts given to professionals. As far as possible,
6 the same judge leads the interview and the court
7 process."
8 So that's how it's dealt with there. Reference made
9 here to the Ministry of Justice piloting pre-recorded
10 cross-examination in England as a means of minimising
11 the trauma experienced by victims of abuse. We know the
12 MoJ has piloted that in areas across the country --
13 Kingston, Leeds and Liverpool -- and the Crown
14 Prosecution Service is supporting that in this country.
15 So we have here, don't we, in this document, emphasis on
16 how it needs to be more child-centred, the process
17 needed to be more child-centred.
18 If we can then, with that in mind as the backdrop to
19 your first statement, go back -- that can come off the
20 screen, Mr Hyde. If you have your statement near you,
21 Ms Harewood, for these purposes, let's see what happened
22 and how The Lighthouse provides services now.
23 We see at paragraph 2.1 -- who is The Lighthouse
24 available to?
25 **A. So The Lighthouse is just available to children in five**

1 **north central London boroughs, so that includes Camden,**
2 **Islington, Haringey, Enfield and Barnet. It is any**
3 **child up to the age of 18 or a young person 18 to 24**
4 **with a learning disability.**
5 Q. What can children expect from The Lighthouse?
6 **A. I think they can expect, really, a holistic service all**
7 **under one roof in a place where they can really feel**
8 **safe to talk. So we aim to allow them to tell their**
9 **story and gather the best evidence, whether that's**
10 **through a forensic examination, as you were hearing**
11 **Dr Steele describe earlier, or through a video-recorded**
12 **interview.**
13 **We want to help them get the best out of**
14 **the criminal justice process by supporting them through**
15 **that, to give them a really holistic medical and then**
16 **provide the emotional and well-being support not only**
17 **for them, but also for their family as well.**
18 Q. Prior to the child attending for initial assessment, is
19 there input from social care about the background of
20 the child?
21 **A. Yes, in two ways, really. We have a social care liaison**
22 **officer based at The Lighthouse and they liaise closely**
23 **with the local social worker. Sometimes our social**
24 **liaison officer and the paediatrician both attend**
25 **a strategy meeting and a local social worker attends on**

1 **the day of the first initial assessment. So we are very**
2 **closely linked in.**
3 Q. Do you see continuity in the attendance of the social
4 worker, a particular social worker, not somebody who
5 doesn't know much about the case, but somebody engaged
6 with the process of The Lighthouse and the child?
7 **A. Yes, we do see continuity and the social workers have**
8 **found it really supportive, actually, using the service.**
9 Q. At paragraph 3.5, you set out what the initial
10 assessment can include. Can you just summarise that for
11 us, please?
12 **A. Yes. So obviously there's an immediate look at the**
13 **child's -- any safeguarding concerns and to make sure**
14 **the child is safe in their environment. That's our**
15 **paramount. We will undertake a holistic medical**
16 **examination. We will assess their emotional needs and**
17 **think about how we can support them and their family.**
18 **There's a play specialist involved to help with that**
19 **process. Then our advocates, which are usually child or**
20 **young people's advocates, will be able to start to make**
21 **sure the voice of the child is heard in that first**
22 **examination, but also they will be there to walk the**
23 **journey with them as they go on through to a criminal**
24 **justice process.**
25 Q. Is that medical examination contemplated in cases where

1 it's non-recent sexual abuse? In other words, where
2 there's no attempt to obtain evidence that corroborates
3 allegations of a criminal offence, but it's a holistic
4 assessment in any event, a health assessment?
5 **A. Yes, it's always something that we offer.**
6 **Interestingly, you will be surprised how reassuring it**
7 **is for young children. Some who may have been abused,**
8 **perhaps aged 7 or 8, who, as a teenager, are worried**
9 **today about whether they have been damaged, whether**
10 **a boyfriend today would know what happened to them when**
11 **they were 7. So it is an incredibly reassuring part of**
12 **the process.**
13 Q. So it can address a young person's health concerns
14 irrespective of the offending years before?
15 **A. Yes.**
16 Q. Do you have a primary case worker?
17 **A. We do, yes. So it can vary who it is, and it can vary**
18 **slightly through the child's journey with us, but there**
19 **will always be somebody allocated to be their primary**
20 **case worker. Often it will be a therapist or an**
21 **advocate.**
22 Q. What's the therapeutic support that the child and the
23 family, perhaps, can be offered?
24 **A. So they will be offered a menu of options, really;**
25 **usually some one-to-one support, which could be with**

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1 **a CAMHS practitioner, or with one of our NSPCC**
2 **therapeutic programmes. Their parents are invited along**
3 **to a parents' psychoeducation course, which is very**
4 **supportive, to help them build resilience, to help**
5 **support their child. Maybe there will be some child and**
6 **family sessions jointly, together, and also we support**
7 **the school, which is very important, because that's**
8 **where the child spends a lot of their time. So we will**
9 **support the teacher to then be able to support the child**
10 **in school.**
11 Q. Two bespoke roles you tell us about are the social care
12 liaison officer and the police liaison officer. Can you
13 tell us about those two roles, please?
14 **A. The social care liaison officer is the expert in**
15 **safeguarding for us within The Lighthouse. But also**
16 **a good liaison to their local social workers. Often**
17 **social workers -- it might be the first time they have**
18 **managed a sexual abuse case, and so our social care**
19 **liaison officer can support them to manage that the best**
20 **way for the child.**
21 **Also the social work liaison officer does a lot of**
22 **training and education. So we trained some 500 people**
23 **within our first few months of opening and we saw**
24 **a threefold increase in referrals. So now we see one in**
25 **two of the children that report to the police, whereas**

1 **it used to be one in four or even less.**
2 **They built the confidence in the social workers to**
3 **refer and dispel the myths that Dr Steele was talking**
4 **about earlier of the medical.**
5 **Then the police liaison role. It's a similar role.**
6 **They are the experts in criminal justice for us. So,**
7 **for example, when we set up our parent course, we sought**
8 **advice from them about how to do that safely without**
9 **impacting on the justice process. They liaise with the**
10 **investigating officer in the case, and they help us work**
11 **closely with the Crown Prosecution Service to try and**
12 **speed up case progression, which in many cases is still**
13 **taking two to four years.**
14 Q. Can I ask you about ABE interviews and the options that
15 The Lighthouse offers for video-recorded interviews.
16 How is that being set up or conducted within
17 The Lighthouse?
18 **A. So we offer two options: one is that a police officer**
19 **can lead the ABE interview as they would normally, but**
20 **they can do it in the environment of The Lighthouse,**
21 **which means we can set the pace and the tone, we can**
22 **support the child with play specialists and snacks and**
23 **an appropriate environment. We can enable the use of**
24 **intermediaries to support the police-led interview, and**
25 **police have found that a really helpful, supportive**

1 **experience.**
2 **Or the really unique thing we are offering, which is**
3 **the Barnahus model of a psychologist leading an**
4 **interview. So that is a much fuller process. It often**
5 **takes a day. The psychologist will start with**
6 **a pre-interview assessment and work with the child to**
7 **build their confidence to understand their communication**
8 **needs, and then move through the day into the actual**
9 **video-recorded interview itself.**
10 **The children have reported that they just find it's**
11 **really helpful to have that comfortable and gentle**
12 **approach and to have time to explain.**
13 Q. The psychologist, would the psychologist interview
14 children with complex needs or communication
15 difficulties?
16 **A. So they do interview children with complex needs and**
17 **communication difficulties. If it's very severe or if**
18 **a child is under 5, we would additionally bring in an**
19 **intermediary, whose role is specifically to act as an**
20 **independent person to aid with communication. But**
21 **a great example, I think, of the added value**
22 **a psychologist brings is in a case example the other**
23 **week: a young boy aged 9 was becoming very dissociated**
24 **and distracted in the interview and she was able to**
25 **bring him back in the moment with a clapping mirroring**

1 **game, with some stop/start stones they use, with a short**
2 **break. It's a real skill and it was a real pleasure to**
3 **watch, actually, her be able to bring the interview back**
4 **on track in a way that I imagine some police officers**
5 **would have found difficult to do.**
6 Q. You have produced already your annual report, 2018 to
7 2019. The reference, Mr Hyde, if we could have it on
8 the screen, please, is MPS004436, internal page 10.
9 I don't have the inquiry reference page, but hopefully
10 we can land on page 10, which is feedback from achieving
11 best evidence interviews.
12 You were referring earlier to the feedback you have
13 had from young people who have attended for an ABE on
14 their experience and that they report feeling listened
15 to and understood and that the clinical psychologist
16 that led the interviews were kind and gentle and the
17 fact they were able to explain everything in detail.
18 We see there the comments that people can read in
19 respect of those interviews. Reference is made to
20 fantastic interview techniques, as you just have. To be
21 clear, the police retain control and responsibility for
22 the interview in that second model, do they?
23 **A. Yes, absolutely. Part of that pre-interview assessment**
24 **is, first, the professionals meeting, where the officer**
25 **and the psychologist will discuss the points to prove**

1 **and the limited outline of the case. The officers are**
2 **controlling in the control room at all times, and at all**
3 **the breaks they continue to communicate and, yes, keep**
4 **in very close contact.**
5 Q. If we can have, please, Mr Hyde, page 28, internal
6 reference page 28, which is visits and learning through
7 the year. You refer there to various briefing partners,
8 and we see the CPS is one of those briefing partners.
9 So is your sense that working with the police and,
10 indeed, the Crown Prosecution Service, there is an
11 appetite for getting this right, if I can put it like
12 that?
13 **A. Yes, there absolutely is, and I've been really**
14 **pleasantly surprised. The Crown Prosecution Service and**
15 **the Metropolitan Police have been so supportive in**
16 **looking at the particular issue we have been struggling**
17 **with, which is case delays, and we meet regularly with**
18 **them to try to promote those as well.**
19 **I think the counter is that what they have seen that**
20 **we have been able to achieve in the Lighthouse is good**
21 **quality evidence that in some cases has led to an early**
22 **guilty plea, so the child not needing to go to court, or**
23 **young people that have made it right through to the**
24 **cross-examination stage and have said, "I wouldn't be**
25 **able to be standing here in court today if it wasn't for**

1 **my advocate at The Lighthouse having supported me". So**
2 **I think the CPS have really found it -- seen the value**
3 **that the service can bring.**
4 Q. The document can go down now, thank you, Mr Hyde.
5 At paragraph 4.6 of your statement, you say the way
6 it works, the police liaison officers provide advice and
7 support to investigating officers to optimise the
8 interview and enabling timely disclosure of notes and
9 escalating delays in the criminal justice process.
10 Record keeping is integral to all of this, isn't it,
11 good and clear record keeping?
12 **A. Yes. One of the things that I think is completely**
13 **unique, certainly in my experience, to running**
14 **a multi-disciplinary service like this is that we have**
15 **one record which the health practitioners, the**
16 **therapeutic practitioners, the NSPCC practitioners,**
17 **social care and police, we all document in the same**
18 **record. Obviously there's a smaller number of user**
19 **access rights for some areas where we need a little bit**
20 **more protection, but generally we have a very robust**
21 **information-sharing agreement, and all of that**
22 **information is in one place.**
23 **So when we are approached by the courts or by the**
24 **police to release information as part of a child's**
25 **investigation, we promise to turn that around within**

1 **30 days. Often it's within a week, which is far, far**
2 **more rapid. When we have looked at some historical case**
3 **delays, one of the issues we found was several months or**
4 **more waiting for third party release of notes.**
5 Q. You say at paragraph 4.6:
6 "The outcomes of the pilot are being evaluated by
7 the Mayor's Office for Police and Crime evaluation
8 teams."
9 Are you very much in a data-gathering process to see
10 how effective this is, this holistic view towards the
11 child and obtaining best evidence in this way?
12 **A. Yes, that's right. Part of the way that our system was**
13 **designed was not only to be a clinical and care record,**
14 **but also to feed the beast, if you like, of evaluation.**
15 **So we are hoping for some really robust data. And the**
16 **children are asked to sign a consent so that, behind the**
17 **scenes, the evaluators can match up our records with the**
18 **criminal justice records, and so they should be able to**
19 **track cases all the way through.**
20 Q. At paragraph 4.7, you set out how, from 2020, children
21 and young people using The Lighthouse services will be
22 able to apply to the court for special measures of being
23 cross-examined via live link from the talking room.
24 Tell us what the talking room is about?
25 **A. Like many of the rooms in The Lighthouse, we have tried**

1 **to give them a child-friendly name. Rather than calling**
2 **it "the ABE suite" or "the VRI suite", we call it "the**
3 **talking room". It is effectively the room where a child**
4 **goes to have their ABE recorded, and more recently we**
5 **have had live link equipment fitted and are just in the**
6 **final stages of being linked up to Wood Green Crown**
7 **Court so that children in future will be able to be**
8 **cross-examined from The Lighthouse as a remote site.**
9 Q. You say that some children still do choose to go to
10 court. You mention that they would prefer to give
11 evidence from court. But there is an option now for
12 those special measures to encompass doing it from
13 The Lighthouse premises?
14 **A. Yes, very shortly, once the last bit of IT is in place.**
15 Q. It hasn't happened yet, you haven't done that yet, you
16 are waiting for the IT?
17 **A. Yes, very close.**
18 Q. The pilot, you say, is in year 2 of 3 and the learning
19 outcomes are still being evaluated. How do you feel, at
20 the moment, it is going? We have seen your 2018-19
21 report, but from the perspective, first of all, of
22 children who have been abused or where abuse is
23 suspected, how is it working for them, this holistic
24 approach to support?
25 **A. I think, from the children's perspective, all the**

Epiq Europe Ltd www.epiqglobal.com Lower Ground 20 Furnival Street
(+44)207 4041400 casemanagers@epiqglobal.com London EC4A 1JS

1 **feedback that we get from them tells us that it's going**
2 **incredibly well. So we have individual anonymous**
3 **feedback from children who have said things like,**
4 **"You've listened to me. You heard my story. My mum was**
5 **so shocked to begin with, but now -- she was so sad, but**
6 **now I can tell her anything", and we have had parents**
7 **giving us feedback from our parent course who found it**
8 **incredibly helpful to be in a room with other parents**
9 **going through similar things.**
10 **I think the last group that's been the really most**
11 **inspiring is the Children and Young People's Forum we**
12 **have set up, who tell us what's working well in the**
13 **service but also what else we need to learn. They have**
14 **helped us just recently design some leaflets that talk**
15 **about the service in their own words, in the voice of**
16 **a child. So I think we feel really reassured that we**
17 **are both providing a service but also listening and**
18 **changing as we need to.**
19 Q. In terms for the police and the Crown Prosecution
20 Service who you say are also engaged in this, and the
21 criminal justice system, do you feel it is encouraging
22 interest around how the best evidence can be obtained
23 from children and effectively, in the end, how those
24 guilty of sexual offences can be prosecuted?
25 **A. I think that's a longer journey and I think it is too**

1 **early, really, to give anything definitive yet.**
2 **Anecdotally, we have had a number of cases, as I said,**
3 **of early guilty pleas. Anecdotally, we have had**
4 **a number of cases where children weren't prepared to go**
5 **through with an ABE interview and then, with the support**
6 **of The Lighthouse, decided that they were.**
7 **Again, anecdotally, we have had young people, who**
8 **perhaps we imagined previously would have pulled out of**
9 **the process, that we have been able to persuade to hang**
10 **on in there for a little bit longer, until their case**
11 **gets to court, which, as I said, can be a long time.**
12 **So it feels like it's really starting to make**
13 **a difference, but only the evaluation will tell.**
14 Q. Is this NHS funded, The Lighthouse?
15 **A. At the moment, the original first two years of the pilot**
16 **were Home Office funded in the main through**
17 **a Home Office innovation fund with additional funding**
18 **from the Mayor's Office for Police and Crime,**
19 **NHS England and the Department for Education. Our third**
20 **year, the funding is from the Mayor's Office,**
21 **NHS England and the Department for Education, yes. So**
22 **it is definitely a multi-agency funding.**
23 Q. You're the only centre in London to provide this
24 multi-agency approach at the moment?
25 **A. Obviously, The Havens is there as a SARC, and they**

1 **provide some elements of the service that we do,**
2 **predominantly for the children that have been abused**
3 **more recently. But, yes, we are the only service of**
4 **this type not only in London, in the country.**
5 Q. When you say the other sexual assault referral centres,
6 would they have the options for taking interviews or
7 assisting with interviews with children?
8 **A. The sexual assault centres across England and Wales,**
9 **many of them have some of the elements of**
10 **The Lighthouse. So many of them have advocacy, some of**
11 **them have counselling, some of them have the options for**
12 **a remote link. None of them, as far as I'm aware, have**
13 **the social care or the police liaison roles, and none of**
14 **them, as I'm aware, have all the elements that sort of**
15 **make it a Barnahus, if you like.**
16 MS LANGDALE: Thank you. I have no further questions,
17 Ms Harewood. I don't know if the chair and panel have.
18 THE CHAIR: Thank you. I have no questions. Ms Sharpling?
19 MS SHARPLING: No, thank you, chair.
20 THE CHAIR: Mr Frank?
21 MR FRANK: No, thank you.
22 THE CHAIR: Sir Malcolm?
23 PROF SIR MALCOLM EVANS: No, thank you, chair.
24 THE CHAIR: Thank you very much.
25 MS LANGDALE: Thank you, Ms Harewood.

1 (The witness withdrew)
2 MS LANGDALE: Chair, that concludes the evidence for today.
3 THE CHAIR: Thank you. We will reconvene tomorrow.
4 (3.22 pm)
5 (The hearing was adjourned to
6 Wednesday, 29 July 2020 at 10.30 am)
7
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