Monday, 7 December 2020
(10.30 am)
Welcome and opening remarks by THE CHAIR
THE CHAIR: Good morning, everyone. I am Alexis Jay, and I'm the chair of the Independent Inquiry into Child Sexual Abuse. With me are the other panel members of the inquiry: Professor Sir Malcolm Evans, Ivor Frank and Drusilla Sharpling.
On behalf of the inquiry, I welcome you all to the substantive hearing into the Effective Leadership of Child Protection Investigation. It is the sixth public hearing to be held remotely by this inquiry. As with other recent virtual hearings, the solicitor to the inquiry sought the views of all core participants in this investigation about the possibility of conducting the hearing remotely. Having received no written submissions in response, I ruled, on 2 November, that a remote hearing was both desirable and practicable.
I would like to thank the core participants, witnesses and representatives for their co-operation in preparing for and conducting this hearing, and to thank the inquiry staff for their hard work in making the necessary arrangements.
The remote hearing will run for five days, finishing on Friday, 11 December. This investigation will examine

the effective leadership of the institutions that fall within the inquiry's terms of reference. This investigation builds on the inquiry's findings on leadership in the interim and investigation reports and it focuses on practical experiences of leadership and management and will examine how effective leadership can better protect children from sexual abuse.
Before we hear from Mr Brian Altman QC, lead counsel to the inquiry, some points on timing. We will begin hearing days 2 to 5 at 10.00 am. The timings for each day of the hearing are set out in the hearing timetable, which was published on the inquiry's website. We will take a 15-minute break every hour, and a one-hour break for lunch. We intend to sit no later than 4.00 pm each day.
By way of an agenda, we rely on the hearing timetable which sets out the order in which witnesses will be called, save for where unforeseen circumstances require a change to be made.
A simultaneous hearing transcript will be produced and is available to those taking part in this hearing via a web browser. The transcript will be published at the end of each day on the inquiry website, and any directions arising from the day's hearing will also be published on the website.

Participants are asked to mute their microphones and turn off their camera unless they are speaking. If microphones pick up noise, such as typing, they will place the person on screen as if they were speaking. Turning off cameras will keep the screen from becoming distracting by looking too busy for those using the gallery view.
I have made a restriction order protecting the identity of complainant core participants and covering the redactions and ciphers applied in this investigation. For technical reasons, it will not be possible to broadcast this hearing with the usual three-minute delay. All witnesses and core participants have been reminded of these restriction orders, and of the need to take great care in giving evidence or addressing the inquiry to avoid any inadvertent breach of these orders.
If there is an inadvertent breach of a restriction order, I will make an immediate further order over the evidence incorrectly given. Members of the public and the press will be prohibited from publishing that evidence.
Counsel will provide more information about the victim and survivor evidence we will be hearing in his opening. Please now go ahead, Mr Altman.

Opening statement by MR ALTMAN
MR ALTMAN: Thank you, chair. Chair, as you know, I am lead counsel to the inquiry and to this investigation. I am assisted by Ms Hill QC and by Mr Fullbrook.
This is, as you have said, the public hearing in the Effective Leadership of Child Protection Investigation and it is the 15th and final inquiry investigation into child sexual abuse in various forms and contexts.
During the course of its work, the inquiry has heard of several institutional and leadership failures, and has made interim recommendations for significant change to organisations' structure, practices and procedures.
Indeed, in its interim report published in April 2018, the inquiry found:
"It is self-evident that the quality of leadership and practice within institutions is critical to protecting children, and to preventing and responding to child sexual abuse. This has been seen consistently across all parts of the inquiry's work.
"It is important to note that the inquiry's consideration of these issues is not restricted to professionals working within the relevant statutory agencies. In accordance with the inquiry's terms of reference, the inquiry's consideration of leadership and practice extends to all those working in state and

non-state institutions that have a role to play in preventing and responding to child sexual abuse -- including those in government, law enforcement, education, healthcare, religious institutions, charities and voluntary sector organisations."

In light of this, the inquiry has considered it necessary to conduct a final investigation into the leadership of institutions that fall within the inquiry's terms of reference for protecting children from sexual abuse. This is a thematic investigation which will build on its findings on leadership in the interim and investigation reports, and consider further evidence; it won't, however, be focusing on any individual case studies or institutions.

You will recall that a preliminary hearing was held on 26 February of this year, 2020.

There are six core participants represented in this investigation. In a moment, I am going to introduce those core participants who are in attendance today. Each representative only appears on screen if they speak, so as I introduce everyone, I would ask them, please, to unmute their microphone, turn on their video and introduce themselves to you, chair, and the panel. First of all, Mr Berry appears both for the National Police Chiefs' Council, the NPCC, and the College of

Policing. Mr Berry?

MR BERRY: Good morning, chair. Good morning, panel.

THE CHAIR: Good morning, Mr Berry.

MR ALTMAN: Next, Ms Pollock appears for the National Crime Agency, the NCA. We understand that Mr Sheldon QC, who also represents the NCA in this investigation, will be in attendance on Thursday and Friday only. Ms Pollock?

MS POLLOCK: Good morning, chair. Good morning, panel.

THE CHAIR: Good morning, Ms Pollock.

MR ALTMAN: Mr Gullick and Ms De Coverley appear for Ofsted.

MR GULLICK: Good morning, chair, members of the panel. As Mr Altman said, I appear with Ms De Coverley for Ofsted.

THE CHAIR: Good morning, Mr Gullick.

MR ALTMAN: Finally, Ms Ward appears for the Secretary of State for Education.

MS WARD: Good morning, chair and panel.

THE CHAIR: Good morning, Ms Ward.

MR ALTMAN: In addition to those five, the Independent Schools Inspectorate, the ISI, has been recognised as a core participant but doesn't intend to attend the hearing through the Zoom link, but, we understand, will, rather, follow the live link.

Now, the themes which this investigation will consider were set out in the investigation's definition of scope, and they were further elucidated in the

investigate's 30 June 2020 update note, and they are these.

Embedding ethics and values so that they align with policy and practice. What ethics and values are important for ensuring child protection and how can they, or ethics and values in general, be embedded into an organisation? How do leaders promote a positive culture for tackling child abuse?

Next, ensuring organisations are safe and effective at being safe. So, what does organisational safety look like? How can this be achieved and what systems need to be put in place to monitor and record safety? What is the role of governance frameworks and how do leaders ensure that these support their strategy for tackling child sexual abuse? How do leaders ensure that they have clear policies and processes in place to deliver these strategies?

Next, achieving openness, transparency and good communication. What does an organisation that is open and transparent about child protection look like and how can an organisation manage the tension between the need to protect the identity of victims of child sexual abuse, whilst at the same time ensuring that it is open and transparent about any potential risks that it identifies? To what extent do leaders engage with

children when tackling child abuse?

Next, ensuring good communication, the escalation of issues and concerns with clear lines of accountability and good leadership in scenarios where there is no direct line management structure.

Next, embedding and ensuring a culture of continuous learning. What does such a culture look like and how can it be bedded into an organisation?

The next topic, or theme: using management and audit information to understand the institution, its systems and its performance so that systemic warning signs can be identified early. We will examine evidence from a range of different organisations about their management of information and data, including outside the child protection context.

The next theme: responding appropriately to internal and external pressures, for example, from politicians, community leaders, parents, funders and other key stakeholders, so that child welfare and protection is prioritised. We will consider what the sources of external and internal pressure within organisations are, and how they can be managed and harnessed most effectively. We will consider how leaders work in partnership with other agencies and bodies to tackle child sexual abuse.

Next, responding to the evidence of whistleblowers and recommendations from inspectorates, Serious Case Reviews and similar reports. How can organisations create an environment in which whistleblowers feel free and able to raise concerns internally? How can organisations ensure that the evidence of whistleblowers and recommendations from inspectorates, Serious Case Reviews and similar reports are implemented, and implemented by staff at all levels, not just by senior management?

The next theme is learning from past institutional failures, including from adverse events, including embedding a "learning", not a "blaming", culture. So how can past failures be harnessed to produce positive future outcomes? How does leadership contribute to this?

The next theme is exercising good judgment with respect to strategic priorities and risks. What are the strategic priorities and risks for organisations involved in child protection? How can leaders and organisations ensure that they exercise good judgment in relation to them?

The relevance of leadership style and how leaders act as positive role models is a further theme. How much difference does leadership style make to the

culture and practice of organisations? Which styles have positive impacts and which have negative impacts? How influential can leaders be as role models? How can this drive child protection? How do leaders motivate and develop their staff?

Lastly, effective leadership, change and improvement. How can leaders most effectively manage and ensure continuous improvement and innovation, and how is this change implemented?

What has the inquiry heard so far about leadership?

In addition to the interim report to which I have already referred, the inquiry has identified and reported on a number of leadership failures during the course of its 14 investigations. These have contributed to the scoping and development of this investigation.

Let me set out some examples now which relate to the individual themes of this investigation.

Embedding ethics and values so that they align with policy and practice. Chair, in the course of this inquiry, you have heard evidence of leaders failing to embed the ethics and values relating to child protection into organisations so that they actually change policy and practice. One example was observed in your investigation into allegations of child sexual abuse linked to Westminster. In your report, you said:

"We also heard evidence, notably from the Green Party and the Labour Party, to suggest that there are major gaps in the practical knowledge of even senior people about basic safeguarding principles. It is a matter of grave concern that, even after a significant public outcry about allegations of child sexual abuse linked to Westminster, elected politicians and officers of political parties do not understand how to respond to allegations properly, or consider themselves in a position to make judgments about whether abuse is sufficiently serious to warrant referral."

As for the theme ensuring organisations are safe and effective at being safe, chair, you have seen that leaders play an important role in ensuring that their organisations are safe. In the inquiry's investigation into children in custodial institutions, you heard from Angus Mulready-Jones, an inspector of prisons, and quoting from the inquiry's investigation report, you said:

"The quality of leadership [in custodial institutions] is not good enough to address the many and complex issues at stake."

The next theme: achieving openness, transparency and good communication. Chair, in the course of the inquiry's investigations, you have concluded that

a failure of an institution to act openly and transparently can have significant consequences. The Anglican Church case studies report included this finding:

"There were a number of occasions on which allegations that ought to have been reported immediately to external authorities were retained internally for as long as possible. The church not only declined to share serious allegations with the relevant statutory agencies, but in at least one case no steps were taken to report known sexual abuse to the police by senior clergy. The absence of co-operation hindered the progress of criminal investigations and safeguarding arrangements and enabled abusers to escape justice."

The next theme is ensuring good communication, escalation of issues and concerns with clear lines of accountability and good leadership in scenarios where there is no direct line management structure. In the same report, you identified a clear example of where a failure to set out clear lines of accountability led to increased safeguarding risk. In the report, in relation to Diocese of Chichester, you said:

"As a result [of clashing personalities], there was no central oversight of the appointment of clergy within the Diocese of Chichester. No policies existed to

ensure the central retention of files. Decisions were not made and leadership, in respect of safeguarding, was not effective because relationships were poor. As the Archbishops' Council itself conceded: 'The lack of definition of roles and responsibilities, and uncertainties about accountability brought about by the area scheme, contributed to a chaotic and unsatisfactory safeguarding environment'."

As for embedding and ensuring a culture of continuous learning, in your report into the inquiry's investigation into child sexual abuse at Cambridge House, Knowl View and Rochdale, you observed the importance of leaders demonstrating a commitment to continuous learning and to addressing issues. You said:

"Diana Cavanagh, the Director of Education, commissioned reports and produced her own report. While some of this of useful, each of the reports was flawed in some respects, including factual accuracy. There was no urgency on the part of these senior officials to address the problems of sexual abuse at the school, and matters were left to drift."

The next theme is using management and audit information to understand the institution, its systems and its performance, so that systemic warning signs can be identified early.

In the same report, you emphasised the importance of leaders making their own enquiries into the performance of their institutions in order to identify issues as they arise and avoid misplaced reliance on others. You said:

"Although [Paul Rowen, leader of Rochdale Council] ... boasted that the style of his administration was to be a departure from the past, his misplaced reliance on council officers allowed him to sidestep his own responsibility, and blame others when he never made any, or any sufficient, enquiry either about the really serious problems that affected [Knowl View] ... school and its children or the efforts to deal with those problems while he was leader. This demonstrated a lack of judgment and a failure of leadership."

Effective use of management and audit information can enable leaders to spot warning signs themselves and ensure that they take responsibility for addressing them.

On the same theme, chair, in the Nottinghamshire Councils' investigation hearing you heard evidence from David White, the former director of Social Services at Nottinghamshire County Council from 1989 to 1994 about the lack of any preordained system for reporting

concerns about child sexual abuse to the council's Social Services Committee. This is what he had to say. Can we play the clip, please?

(Video played)

In your report into Nottingham Councils, you said:

"The extent of sexual abuse in foster care in the 1970s and 1980s was compounded by poor decision making in those cases where disclosure had been made. Some known perpetrators were permitted to remain as foster carers, and then went on to abuse again. Despite the county's assessment of the prevalence of sexual abuse for children in foster care in the early 1990s, David White, the director of Social Services, failed to take any effective action ... This should have prompted an assessment, at a senior level, of the scale of abuse, why it was happening and how the risk of abuse could be addressed. Despite occasional attempts to consider the issues more broadly, the county failed to address the risk of abuse to children in their care ... Despite being regularly informed of disciplinary action taken against staff (but not foster carers) following investigations into sexual abuse of children in residential care during the late 1980s and 1990s, the county councillors responsible for oversight of children's social care did not question the scale of

sexual abuse or what action was being taken. This was a serious failure of scrutiny and governance."

Turning now to the next theme: responding appropriately to internal and external pressures, for example, from politicians, community leaders, parents, funders and other key stakeholders, so that child welfare and protection is prioritised. The importance of senior leaders acknowledging and responding to internal and external pressures was identified in your report into Nottinghamshire Councils, in which you said:

"Nottinghamshire Police's investigation into allegations of non-recent sexual abuse of children in residential care (Operation Daybreak) was not adequately resourced or supported from its formation in 2011 until 2015. Given the increasing number of allegations of abuse and the criticisms from internal and external reviews, senior police officers should have done more to support the operation. The police did not treat the allegations with sufficient seriousness."

Now, responding to the evidence of whistleblowers and recommendations from inspectorates, Serious Case Reviews and similar reports. The extent to which organisational culture can create barriers for those wishing to report behaviours of concern was identified, chair, in your report into allegations of child sexual

abuse linked to Westminster. Commenting on the response of the police, you said:

"A second form of deference we have heard about is a more internal kind within institutions themselves, such as where junior police officers did not challenge senior officers' questionable decisions during investigations of the powerful for fear of harming their own career prospects."

In addition, a clear example of a failure to have due regard to external child protection recommendations can be seen in your report on child sexual abuse within the monastic communities at Ampleforth and Downside. You discussed the independent review on child protection in the Catholic Church, known as the Nolan Report. You explained that in Ampleforth, the abbot, Timothy Wright, "held strong views about child sexual abuse allegations which amounted to a repudiation of the Nolan recommendations. Although he initially appeared to engage with the recommendations, in essence, he wanted nothing to do with their implementation.

Moving to the next theme: learning from past institutional failures, including from adverse events, including embedding a "learning", not a "blaming" culture. The failure by leaders to grapple constructively with reports of previous failures and to

institute a learning rather than a blaming culture was demonstrated by the Anglican Church's response to abuse by Peter Ball and within the Chichester Diocese. In your report, chair, you said:

"Several internal reviews failed to expose the nature and scale of the problem of child sexual abuse within the diocese. Instead, they were used by church leaders to act out their personal conflicts and antagonisms. The reviews ultimately came to nothing until the Archbishop of Canterbury intervened by ordering a Visitation."

The next theme is: exercising good judgment with respect to strategic priorities and risks. An example of a failure to exercise good judgment with respect to risk can be found in Lord Steel's handling of allegations against the late Liberal Party MP Cyril Smith. In your report into allegations of child sexual abuse linked to Westminster, chair, you said:

"Lord Steel told the inquiry that the allegations had arisen before Cyril Smith had become a member of the Liberal Party and he saw 'no reason, or no locus, to go back to something that had happened during his time as councillor ...'. In effect, that it was nothing to do with him. This failure to recognise the risk that Cyril Smith potentially posed to children was an

abdication of responsibility by a political leader and an example of a highly-placed politician turning a blind eye to something that was potentially troublesome to his party, with no apparent regard for criminal acts which might have occurred or for any victims, past or future."

You also said:

"In 1979, Lord Steel (the leader of the Liberal Party) 'assumed' Sir Cyril Smith had committed offences of child sexual abuse. In our view, rather than give primacy to the protection of children, he yielded to considerations of political expediency and failed to launch a formal internal inquiry into Smith's alleged activities."

Let me turn now to the next theme: the relevance of leadership style and how leaders act as positive role models. Chair, you will recall in the inquiry's investigation hearing into the Roman Catholic Church: Ealing Abbey and St Benedict's case study, you heard evidence from Abbot Martin Shipperlee, the Abbot of Ealing, about the way he handled child sexual abuse allegations at Ealing during his abbacy. He said of his own failings in this regard:

"As has been serially revealed, my administration of safeguarding is of an insufficient standard ... I have made at least one extraordinary -- a very serious

mistake which isn't creditable [sic] to me and that my brethren who have offended have done serious wrong. I can only apologise for what I've done wrong ..."

The following day, Abbot Shipperlee's resignation was announced by the Abbot President of the English Benedictine Congregation, Abbot President Christopher Jamison, at the outset of his evidence to you and the panel. This is the clip of what he had to say.

(Video played)

Chair, in your report into child sexual abuse at Ampleforth and Downside, you highlighted the impact of Abbot Timothy Wright's leadership style. You said:

"He clung to outdated beliefs about 'paedophilia' and had an immovable attitude of always knowing best. For much of the time under consideration by the inquiry, the overriding concern in both Ampleforth and Downside was to avoid contact with the local authority or the police at all costs, regardless of the seriousness of the alleged abuse or actual knowledge of its occurrence."

In your report into child sexual abuse at Cambridge House, Knowl View and Rochdale, you said of Richard Farnell, a former leader of Rochdale Council:

"Regarding Mr Farnell's final statements at the

hearing, it was shameful that he refused to accept any personal responsibility for the young lives blighted by what happened at the school while he was leader. Instead, he laid all blame for what occurred at the door of the senior officials in education and Social Services ...

"While Mr Farnell washed his hands of Knowl View, some of Rochdale Council's beleaguered officers were left to sort out its many problems. We agree with Ms Hoyano that Mr Farnell was, at the very least, wilfully blind to Knowl View School during his time in office ..."

I'm going to now ask the evidence handler to play the relevant clip of Mr Farnell's final statement at the hearing.

(Video played)

It should be noted that, after providing that evidence, Mr Farnell told the inquiry in writing, and this was also set out in your report, chair:

"As council leader during the period of 1986 to 1992, I unreservedly accept political responsibility for the actions of the council and its staff and in this case its lack of care and failure to act to protect children, which occurred under my leadership."

Now, chair, to the final theme: effective

leadership, change and improvement. The importance of leadership in driving necessary change was illustrated by the panel's report into the Anglican Church's response to abuse by Peter Ball and within Chichester Diocese. Commenting on the diocese's response to internal reviews of its handling of child sexual abuse allegations, you said:

"The Diocese of Chichester's Past Cases Review in 2008-2009 did not unearth the full scale of the abuse that was taking place inside its doors. It failed to take into account the actions of all volunteers and retired clerics. Despite the limitations of this review, the issues that it did raise should have been considered and dealt with by the diocese at the time. This would at least have served to reduce the risks to children and young people. The relationship between Bishop John Hind and Bishop Wallace Benn collapsed during this key period. Their personal conflict distracted the Diocese of Chichester from more pressing matters, particularly the need to address the findings of Mr Meekings and Lady Butler-Sloss. Numerous meetings and discussions took place but seemed to focus on internal squabbles between senior clerics, rather than on the welfare of victims of child sexual abuse ... Bishop Benn failed to recognise that his actions

contributed to a paralysis in the diocese. He laid the blame for his own failings on others, including junior members of staff."

Overall, chair, it is clear from these examples and others which the inquiry has seen that failures of leadership can significantly harm an organisation's ability to protect children from harm. The purpose of this investigation is to explore how those failures can be avoided.

Whilst the report findings provide context for the evidence which you will hear this week, there is no more important context, we suggest, than the powerful and compelling evidence which the inquiry has heard directly from victims and survivors of child sexual abuse. It demonstrates the harm that can arise from ineffective leadership. We are now going to hear two examples of this evidence which illustrates the real-world impact of leadership failures.

The first is PR-A10, who gave evidence to the inquiry's investigation into child protection in religious organisations and settings. PR-A10 was sexually abused at the age of 12 by a communion steward within the Methodist Church. She now works supporting victims of abuse. In 2018, she made a formal complaint to the Methodist Church and asked it to review the way

in which it had handled her case. In the extract we are about to play, she provides her comments on the church's response and the importance of institutions learning from past mistakes. Before we play the extract, I should add that, in order to provide additional protection of her identity, her voice has also been modulated. Here is what she had to tell the inquiry.

(Video played)

The second example is Julie Macfarlane, who gave evidence in the inquiry's investigation into the Anglican Church. Ms Macfarlane gave evidence that she was sexually abused by a Church of England rector, AN-F12, at the age of16. She now works as a legal academic specialising in conflict resolution. In the extract we are about to see, she provides her comments on the church's handling of a civil claim which she made against it, and in particular her concern that the church's outward pronouncements didn't match its internal workings and gave the impression of a lack of transparency.

(Video played)

In order to ensure that this investigation is grounded in these experiences, and to ensure that institutional evidence is tested from a range of perspectives, we have allocated space throughout the

timetable to read or replay relevant evidence from victims and survivors which the inquiry has already heard in other investigations and which relates to the themes we are examining here.

Chair, it is a little before 11.30 am. I wonder if that would be a good opportunity for you to take your break?

THE CHAIR: Thank you, Mr Altman. We will return at 11.45 am.

(11.30 am)

(A short break)

(11.45 am)

THE CHAIR: Mr Altman?

MR ALTMAN: Let me now come to the evidence and the timetable to come. Over the course of this week, you will hear evidence from a wide range of perspectives and from a range of sectors, some of which have been selected because they have not been the subject of any detailed consideration by this inquiry before.

The evidence is going to start today, when you will hear from academics and professionals who will help to set the context for this investigation by addressing some theoretical elements of leadership and identifying broad areas where leaders have gone wrong in the past and opportunities for future improvement.

Tomorrow, Day 2, will focus very broadly on the education sector. The day will start with an excerpt of evidence given in the inquiry's Residential Schools Investigation by a victim and survivor of child sexual abuse perpetrated by a teacher at his school, RS-A7. You will then hear evidence from two headteachers, one serving and one retired, about their practical experience of providing leadership within schools. Following that, you will hear evidence from Karen Manners, who is the interim chair of the Child Safeguarding Practice Review Panel, and Barbara Firth, who has an extensive background in social work, about the mechanisms in place for reviewing and learning lessons from serious child protection failures, and also about any leadership themes and trends which these reviews have identified. The day will conclude with evidence from officials from the Department for Education and the Welsh Government about the role of central government in providing and facilitating effective leadership of child protection.

Day 3 will focus, again very broadly, on the local government and care sector. As with Day 2, the day will commence with an excerpt of evidence from victims and survivors -- in this case, from two people who were sexually abused whilst in care and who gave evidence to

the inquiry's Lambeth investigation -- LA-A138 and LA-A354. You will then hear evidence from Dame Stella Manzie and Lord Michael Bichard, both of whom have experience of local government leadership and leadership in the wider public sector. Following this, you will hear evidence from groups representing social workers and children in care, and then from a local politician and director of a group which provides children's care services.

Day 4 is going to commence with evidence from representatives from independent third sector organisations which provide services for young people. We will then hear evidence from the Football Association and the Scouting Association, two large organisers of voluntary activities for young people, about the particular safeguarding and leadership challenges that arise in this context. The second half of the day will focus on leadership in the criminal justice system, with evidence from two senior police officers, one retired senior police officer and a Chief Crown Prosecutor.

On the final day, Day 5, we will start with an excerpt of evidence given to the inquiry's investigation into Child Sexual Exploitation by Organised Networks by a victim and survivor of sexual abuse and by the mother whose daughter was abused, CS-A2 and CS-A12. They

comment on a series of institutional failures of leadership. You will then hear evidence broadly relating to the health sector, from Sir Robert Francis QC and Sir David Behan CBE, the former chief executive of the CQC. The investigation will close with the account of a victim and survivor of child sexual abuse who gave evidence to the inquiry's investigation into Nottinghamshire Council, NO-A51, and whose evidence will be read to the investigation in particular about the way in which leaders can work with victims and survivors to improve child protection overall.

Chair, a few words about logistical issues regarding the evidence. As is usual, the material obtained for this investigation has been redacted and ciphers have been applied, where the inquiry considers it appropriate, in accordance with the inquiry's protocol on the redaction of documents. There are restriction orders in place that protect the identities, names, addresses and images of any complainant core participants and also the identities of any individual whose identity has been redacted and/or ciphered by the inquiry and any information redacted as sensitive and irrelevant.

Chair, you have ruled that these hearings will be held virtually by Zoom and live streamed, as you

mentioned when opening this investigation.
For those anonymous witnesses who have already given evidence in other investigations whose evidence we propose to replay, counsel will be visible on the screen, the witness will not be visible, but their voice will be heard. Due to the nature of the live stream, it is not possible to subject the broadcasting to a three-minute delay, which you have already mentioned. All witnesses will be reminded of the meaning and effect of any restriction order by their legal representatives and the inquiry legal team before giving evidence and of the need to refer to ciphers for those covered by them and who should remain anonymous.
We do invite the assistance of all concerned in respecting the processes in place and promptly drawing to our attention any issues that arise in respect of a breach of a restriction order so that the live stream can be terminated and the matter then resolved. Guidance has been given to core participants how to raise a matter with us in this remote hearing.
If there is a breach of a restriction order, counsel to the investigation will say words to the effect of, "An issue has arisen as a result of which I invite you, chair, to terminate the live stream and make an immediate further restriction order covering the

evidence just given."
We will then invite you to take a short break while the issue is explained to the witness.
Chair, that concludes what I have to say to you in opening. You are now going to hear an opening statement from Ofsted, the only core participant who wishes to make one. We will then proceed to the evidence, with Mr Fullbrook reading the statement of Dr Ian Peters, and we turn to the live evidence this afternoon. Thank you, chair.
THE CHAIR: Thank you, Mr Altman. Would counsel for Ofsted please go ahead?
Opening statement by MR GULLICK
MR GULLICK: Thank you, chair. Chair, effective leadership is of major importance when preventing and responding to the sexual abuse of children. Ofsted, the Office for Standards in Education, Children's Services and Skills, is grateful for the opportunity to participate in this important final phase of the inquiry as a core participant.
The inquiry has received evidence in relation to this investigation from Her Majesty's Chief Inspector, Amanda Spielman, and Ofsted will make more detailed submissions in relation to that and the other evidence before the inquiry in its written closing.

In this opening statement, Ofsted will highlight some of the themes and issues which the inquiry may wish to consider in this investigation.
Ofsted has specific inspection criteria for leadership in each of the remits it regulates and inspects. The importance of effective leadership is clear from Ofsted's inspection reports and its wider publications. The impact of safeguarding arrangements is tested in all types of setting and service, and effective leadership of safeguarding is key.
Ofsted's findings in these areas will always contribute to the overall judgment on those criteria.
Ofsted sees many good examples of leadership in the institutions and local authority that it inspects and regulates, including in schools, children's homes and the secure estate. Where Ofsted finds that settings are inadequate, the universal theme is weaknesses and failings in leadership and management. This is most commonly found in terms of ineffective oversight and poor monitoring systems and a lack of direct sight of what is happening for children.
Weaknesses in leadership are seen across the range of settings. Where Ofsted has required children's homes to act to improve the safety and protection of children, this is most often to address weak leadership and

management. Complaints to Ofsted about schools are predominantly about leadership and management, pupils' well-being or both. Effective leadership is, therefore, especially important not just at the national, regional or local authority level, but within each individual setting where children are looked after or educated.
Conversely, where settings are improving, they tend to show characteristics of good leadership, something set out in Ofsted's recent annual report for 2019/2020 in relation to what are described as "stuck" schools, that is, schools that have not had a rating of "good" or "outstanding" since 2007.
The inquiry has raised several questions about effective leadership in child protection. As a core participant, Ofsted wishes to focus in this opening statement on three areas to which the inquiry may wish to pay particular attention. Firstly, the key qualities of an effective leader. Secondly, how leadership has been impacted by the COVID-19 pandemic. And, thirdly, what needs to change.
Turning briefly to the first of those areas, the key qualities of an effective leader. Not all good leaders possess the same qualities, but many leaders do appear to share a common set of talents, values and behaviours. Ofsted has conducted its own research into the qualities

of effective leadership to improve its inspection practice. Ofsted's 2015 report into effective leadership of children's services drew on evidence from visits to nine local authorities and identified the following common characteristics of effective leaders in children's services:

Openness to possibilities; the ability to collaborate; demonstrating a belief in their team and people; personal resilience and tenacity; the ability to create and sustain commitment across a system; focusing on results and outcomes; the ability to simplify; and the ability to learn continuously.

Similar findings were made in the research conducted to develop Ofsted's current education inspection framework in use from September 2019 which is set out in more detail in Ms Spielman's evidence.

Ms Spielman has also set out two additional principles in her evidence: honesty and integrity. These are essential characteristics for leaders ensuring effective child protection in any organisation.

During the inquiry's previous investigations, Ofsted has given evidence about leaders who do not act honestly or with integrity or who conceal child protection matters. Ms Spielman has also given evidence about the need for ethical working.

Leaders set the tone for their organisations, and need to ensure a culture of openness and transparency so that children and staff can speak out. Ofsted is interested in learning, as the inquiry examines the evidence during the course of this investigation, how all these qualities are recognised across the wide range of different sectors giving evidence -- in education, local government, the voluntary and third sector, the criminal justice system and in health.

Turning to the second of the areas I referred to earlier, the impact of the COVID-19 pandemic on leadership. Both the education and social care systems have been severely disrupted by the pandemic. The effect on the safeguarding of children cannot be underestimated. Effective leadership in this context and at this time and in the future whilst the pandemic continues and its effects continue to be felt is therefore of particular importance.

Given the timing of this investigation, the inquiry is well placed to consider these issues.

Ofsted has seen many good examples of effective leadership during this pandemic. It has also seen poor examples of leadership and examples where leaders have struggled under the strain the pandemic has brought on all of us.

Ofsted looks forward to hearing a range of examples this week about how child safeguarding issues raised by COVID-19 are being dealt with well by leaders and recommendations from different sectors about how to maintain effective leadership in child protection during this difficult time.

The pandemic has highlighted the critical role that schools play in children's lives. Ofsted's findings from its interim visits to schools showed the great effort leaders have made to respond to the challenge of fully re-opening. Many leaders told inspectors that they have progressed safeguarding training during the months when schools were closed during the first national lockdown. This included training on identifying and addressing safeguarding concerns while pupils were being educated remotely.

Ofsted has seen falling referrals to children's social care because of school closures. This is of significant concern. This is changing as schools return, but there is concern that some children, particularly those for whom their homes may not be a safe space, are still hidden from view because of the lack of professional involvement in their lives. Many children have not returned to school at all. Many children with special educational needs and

disabilities, and their parents, have particularly struggled during lockdown as many services and sources of support, social care, educational and therapeutic have been disrupted or withdrawn. COVID-19 has undoubtedly added another layer of complexity to the child protection sphere and the way in which leaders have addressed their responsibilities in this respect during the pandemic and how they have learned from and adapted to the unprecedented circumstances, including changing patterns of child sexual abuse and exploitation, may be of particular interest to the inquiry.

Many of the leaders that inspectors spoke to, particularly in early years, and in local authorities, have felt financial pressures as a result of the pandemic. Ofsted has also found that schools that are graded higher for leadership and management than for overall effectiveness are disproportionately in deprived areas. To what extent do limited budgets, capacity and resources and the social and economic context of settings in which children are looked after affect effective leadership in the field of child protection? This is an issue that Ofsted hopes will be addressed during the investigation.

Compounding this, leaders across all sectors have

told inspectors they and their teams have felt added stress and uncertainty this year. All sectors are showing signs of fatigue. This is something Ofsted is greatly concerned about and is something it hopes the investigation will consider when looking at the issue of effective leadership.

Turning, finally, to the third area of what needs to change, Ofsted has made a range of recommendations to this inquiry across its several investigations. Many of those recommendations relate to improving requirements on leaders of institutions in order to improve child protection. How such improvements might be taken forward, itself requiring effective leadership in the management of change, may also be an issue that the inquiry wishes to consider during this investigation.

I will briefly turn to some areas on which Ofsted has already made submissions in other investigations.

The police, health and local authorities are together responsible for local safeguarding arrangements. Ofsted has consistently said that no one agency can tackle abuse on its own. It is when agencies work together effectively that there are better outcomes for children. Ensuring effective partnership working is a key responsibility of leaders in these fields. The inquiry had the opportunity to look at partnership

working arrangements in its recent investigation into child sexual exploitation by organised networks. Effective multi-agency working was one of the issues raised by Ofsted in its submissions to the inquiry in that investigation, and leaders at all levels have an important role to play in that respect. This investigation may want to consider whether we can be confident all leaders are appropriately held to account in relation to multi-agency safeguarding arrangements. This is particularly the case in the health sector, with its complex and diverse range of organisations and accountability arrangements.

Ofsted has also made recommendations which relate to improving information sharing and effective partnership relationships. This includes improving links between schools and local authority designated officers, between different local authority departments, across local partnerships and between national level bodies, such as the Teaching Regulation Authority, the Independent Schools Inspectorate and Ofsted itself.

During the Residential Schools Investigation, Ofsted also proposed strengthening the standard for leadership and management contained in the Independent School Standards to ensure that all schools have governance structures that result in headteachers being held to

account effectively.

Given the crucial role that governors play in overseeing safeguarding, Ofsted is also in favour of new standards which introduce mandatory safeguarding training for governors of independent schools. This would support them to carry out their roles which are often voluntary, effectively, and to be critical friends of the schools' senior leaders.

Ofsted has also recommended improvements to various aspects of statutory guidance, such as Working Together to Safeguard Children, and Keeping Children Safe in Education, so that leaders can use these to create and sustain an effective safeguarding system within their setting.

Chair, Ofsted looks forward to hearing the evidence of the witnesses in this investigation and what they each recommend to the inquiry to improve the effective leadership of child protection. Chair, that concludes the opening statement on behalf of Ofsted.

THE CHAIR: Thank you very much. We now turn to Mr Fullbrook.

Summary of statement of DR IAN PETERS MBE (read)

MR FULLBROOK: Thank you, chair. I am now going to read the witness statement which was provided to the inquiry by Dr Ian Peters MBE, the director of the Institute for

Business Ethics. The statement is at URN IBE000013.

He says as follows:

"The Institute for Business Ethics (IBE) has been invited by the independent inquiry into child sexual abuse to submit a witness statement which addresses the principles underlying good ethics policy and practice in organisations including the importance of providing effective speak-up arrangements.

"This witness statement is submitted on behalf of the IBE by Dr Ian Peters MBE, director. As director of the institute, Ian is responsible for implementing strategy, leading the team and ensuring that the institute meets its charitable aims of raising awareness and spreading best practice in the field of business ethics.

"The IBE is an independent educational charity which exists to promote high standards of business behaviour based on ethical values. We were established in 1986 and, for over 30 years, we have advised organisations and organisational leadership on how to strengthen their ethical culture by sharing knowledge and good practice. We believe that doing business ethically makes for better businesses and better results in relationships and reputations with employees and other stakeholders that are based on trust.

"We have developed a business ethics framework to reflect a mature ethics programme which is based on the experience of leading corporate practice from our network of supporter organisations. The framework begins with ethical values which are embedded into organisational culture through an ethics programme, the foundation of which is a code of ethics. This then also needs to be supported by communication and engagement activities, training and reinforcement, leadership, supportive environment and speak-up and risk assessment, monitoring and accountability. This framework forms the structure of our response. A visualisation of this framework is included as a separate attachment."

That's exhibit IB1 of his statement:

"Ethical values.

"For an organisation to demonstrate that it is serious about its commitment to business ethics, the ethical values of the organisation should be reflected along with the business values in the purpose statement of the organisation, in the strategy, governance and ethics policy, as well as in the decision-making process in the organisation.

"It is important to note that not all values espoused by organisations are ethical values. Core value statements of organisations often include

a mixture of ethical value words, such as 'fairness', 'respect', 'integrity', 'care', et cetera, as well as business or operational value words such as 'innovation', 'customer service', 'profitability', 'safety', et cetera. Both are necessary for organisations to thrive commercially, but the balance between the two must be maintained as they potentially drive different outcomes when used as a basis for organisational decision making, whether in the purpose statement, business model, strategy and governance of the leadership of the organisation or in the day-to-day decision making of employees at any level.

"We define business ethics as 'the application of ethical values to business behaviour' and are therefore interested in 'how' business is conducted, that is, is it conducted with respect to stated ethical values rather than 'what' an organisation does, that is, its business model, or why it does it, that is, its purpose?

"To promote ethical decision making in organisations, we advocate the use of decision-making models, whether for the big ticket items in the boardroom or in operational decision making on a day-to-day basis. Posing a series of simple questions, such as, 'Would I be happy to see this decision on the front of the newspaper?', 'What would

happen if everyone in the organisation did this?' or 'Who will this decision affect or hurt?', are effective ways of promoting informed, ethical decision making. Collating short question sets, including those listed above, into a decision-making model or decision tree which can be propagated through the activities of an ethics programme is considered to be best practice. More information about the decision-making models, including examples, can be found in our good practice guide publication, 'Ethics in decision making', which is included as a separate attachment to the statement.

"Responsibility for corporate ethics should sit with the governance of the organisation and our board briefing publication, 'Ethics Risk and Governance', sets out why directors need to be actively involved in setting and maintaining a company's ethical values and suggest some ways to approach it by helping directors define their contribution to the maintenance of sound values and culture. A copy of this publication is included as a separate attachment to the statement.

"Codes of ethics.

"Codes of ethics, or, alternatively referred to as codes of conduct, are the foundation of an organisation's ethics programme. They can be compared to a map offering guidance to staff of what route to

take when there is a choice to make.

"For over 30 years, we have researched the use of corporate codes of ethics and our research shows us that in the last few years there has been a shift in the primary purpose of such documents. Historically, the number one reason given as to why companies have a code of ethics has been to provide guidance to staff. However, when we last conducted this research in 2019, for the first time the leading response was, to create a shared and consistent company culture, suggesting a change in the approach of leading organisations with regard to the focus of their ethics programmes. This research is detailed further in our survey report, 'Embedding Business Ethics: 2020 report on corporate ethics policy and programmes', a copy of which is included as a separate attachment to the statement.

"An effective code of ethics should set out the expectations that the organisation has for how employees should behave in any given situation. The best also set out what employees and other stakeholders can expect from the organisation in return.

"It is also important to note that every code should be tailored to the organisation and that one size never fits all. Our full guidance on codes of ethics is available in our publication, 'Codes of Business Ethics:

a guide to developing and implementing an effective code', which is included in a separate attachment to the statement.

"Codes of ethics should be engaging, user-friendly documents which are written in accessible language and include effective design elements, such as comprehension aids, FAQs, scenarios and dilemmas, to help translate ideas, concepts and standards into day-to-day application. Translation of the text into local languages is also recommended where organisations operate internationally. Additional ways in which codes of ethics can be made accessible is through the utilisation of technology where appropriate. Many organisations now feel that they do not need a printed version of the code and that an online version, whether in PDF, web or even app format, will suffice. Utilising technology can be effective, but must be based on the needs of the workforce. For example, some companies require printed versions of their code to ensure that the content is accessible for offline populations, such as remote or non-office-based workers who may not be provided with a company device or computer time as part of their role.

"Good practice is also to write the code for the benefit of employees but to make it publicly available.

On the last count, 78 of the FTSE 100 do make their codes publicly available through their websites.

"It is important to remember, however, that a code of ethics is necessary but not sufficient on its own and needs to be supported by the additional elements of an ethics programme, as explained below.

"Communication and engagement.

"An organisation's ethical standards must be communicated to employees and relevant stakeholders on a regular basis. Building a drumbeat of communications on ethical issues is critical to promoting employee engagement with ethical issues and creating an environment where employees feel both empowered to do the right thing, ie, make ethical decisions, and supported in doing so.

"Communicating ethical values is not as simple as informing employees about facts, figures and procedures and checking they are compliant. Discussions about ethics must start with concepts that touch employees' own experience. Story-telling is an effective way of achieving this. In many organisations there still exists the language of compliance, punishment and of mistrust. This characterises employees as without ethics and needing to be reeducated into the company way or face punishment. This approach decreases trust and

perpetuates the myth that ethical standards are caused by a few bad apples without looking at the wider company culture.

"Giving employees the tools to enhance their ethical acumen and 'do the right thing', trusting them to make choices in line with ethical values and respecting them when they speak up are values-led ways to produce a 'Pygmalion effect'. If people are seen and treated positively, this influences the way they act in a beneficial way.

"Our full guidance on communications and ethics can be found in our good practice guide publication 'Communicating Ethical Values Internally', which is attached to the statement.

"Training and reinforcement.

"A third activity of an ethics programme which seeks to embed ethics into an organisation and align policies and practices is training. Effective training will provide positive reinforcement of the key messages and commitments espoused and, when done well, for many, it is the best opportunity to see most clearly how potentially philosophical concepts actually apply to their roles.

"Training should not be limited to a compliance tick-the-box approach, focused more on ensuring a set

target of completion/participation rates than on transferring the relevant knowledge and skills required to live up to the organisation's ethical commitments. Such measurement of whether training has been understood and applied is more of a challenge but is possible.

"An effective ethics training strategy should articulate the desired outcomes it is designed to achieve and the indicators that can be used to measure success. More information is provided under the 'Risk Assessment, Monitoring and Accountability' heading below.

"It is important not to limit training or ethics education to a once-a-year learning experience, whether a classroom-based or e-learning session, and to recognise that people learn outside of this environment, informally, through those around them and through their on-the-job experiences.

"The use of scenarios or ethical dilemmas in training is considered to be the most effective use of training time, as they create the experiences which people can learn from without actually creating unethical situations in which to test employees. They help to sensitise staff to the ethical dilemmas they may face in their day-to-day work by giving them the confidence to deal with those dilemmas in a manner

consistent with the organisation's ethical values.

"Leadership, supportive environment and speak-up.

"Fourth, there are a number of contextual elements which impact the ability for ethics to become embedded throughout an organisation and the ability and willingness for employees to adopt the espoused standards of their organisation in their day-to-day work. These include the example of leadership, how supportive the environment they are operating in is and the extent to which they are free to speak up in their place of work.

"Leadership is a key driver of ethical performance in an organisation and much is written about the impact of the tone at the top of an organisation. Leadership is as essential to business ethics as ethical qualities are essential to good leadership. It is the leader of a business that sets the tone of the behaviour of the company. In the immediacy of the organisation a leader is seeking to run, he or she needs to be aware of the example they are personally setting for their employees. On a tribal level, followers try to emulate their leaders as a means of advancement. This is explained further in our publication 'Setting the Tone: Ethical Business Leadership' which is attached separately to the statement.

"It is also important to recognise that there are 'leaders' at every level in an organisation and the tone set locally will have a significant impact on the extent to which a local environment may or may not be supportive for ethics. Therefore, 'tone from above' may be a more relevant concept. Research into embedding ethics in the workplace indicates that employees consider their line manager as the biggest enabler and teacher of ethics in their organisation. The statement quotes or cites Stevens, B (1999) 'Communicating Ethical Values: A Study of Employee Perceptions', in the Journal of Business Ethics, volume 20, number 2, pages 113 to 120.

"Another measure of how supportive the local environment is for ethics is whether or not ethical matters are incorporated into the performance management processes of the organisation. Particularly critical is that the employees are assessed and rewarded based on how they achieve their goals, as well as what they achieve. This is important to emphasise that the ends do not justify the means. This is explained further in our good practice guide publication 'Performance management for an ethical culture' which is attached to the statement.

"Next, the freedom to raise concerns without fear of

retaliation is a core component of a supportive, ethical business culture, one where employees are confident they will be supported to do the right thing. From our latest research, 24 per cent of UK employees tell us that they have been aware of some form of misconduct at work in the previous 12 months. However, only 67 per cent said that they raised their concerns, ie, that they spoke up about the issue. The top reasons those who did not speak up gave were: that they did not want to jeopardise their job; that they thought no corrective action would be taken; and that they did not want to potentially alienate themselves from colleagues. The full results of the survey are available in our publication 'Ethics at Work: 2018 Survey of Employees - United Kingdom' and a copy is attached to the statement.

"To embed a speak-up culture in an organisation, employees must be supported in the ability to speak up when they become aware of misconduct. This can be achieved both through the provision of comprehensive speak-up arrangements and reporting channels, but also through managers creating psychologically safe environments where ideas can be raised and constructively challenged and concerns called out. However, more than just encouraging employees to voice their concerns, they also need to be heard and the

organisation needs to be able to listen up effectively. Finally, once a concern has been raised and heard, it also needs to be followed up appropriately. This will require having appropriate escalation policies and procedures and a thorough, well-equipped and well-resourced investigations process to be able to determine the root causes of the issue and then take appropriate action and develop additional controls to prevent reoccurrence.

"Our good practice guide publication 'Encouraging a speak-up culture' looks at practical ways that organisations can encourage a speak-up culture and includes guidance on establishing and embedding a procedure that gives employees confidence to raise concerns about anything they find unsafe, unethical or unlawful. A copy of that publication is attached to the statement.

"Risk assessment, monitoring and accountability.

"Lastly, risk assessment, monitoring and accountability are also core components of a mature ethics programme. However, good practices on these three areas are not as well developed as they are in other parts of the framework.

"The conducting of risk assessments allows for the prioritisation of resources on the biggest risks facing

an organisation from an ethical perspective. For many, ethical lapses and scandals play out as a loss of trust and damaged reputation which result from poor behaviours. For an ethics programme to be effective, the severity and likelihood of the risks needs to be understood so that they can be effectively managed through appropriate controls.

"Second, the ethical culture of an organisation should be proactively monitored to ensure that any pockets of weak culture are identified and addressed. As noted above, many directors agree that culture cannot easily be measured. However, there are many proxy indicators of culture in existing management information, and boards can, and do, have access to a range of information which sheds light on the drivers of behaviour within their organisation and will help them to shape it in the desired way.

"Most regularly, boards look at speak-up and whistleblowing data, the results of employee surveys and health and safety data, as well as items in the public eye, such as taxation policy and diversity. Less attention is paid to issues such as customer complaints, supply chain data, social media records and exit interviews, all of which might provide important insight. Directors also need both quantitative and

qualitative data, but where KPIs are concerned, they need to look beyond the raw figures to understand the underlying message and compare results with other indicators to see whether they confirm the picture. More on the information received by boards, how they consider it and how they report on culture to the outside world, can be found in our board briefing publication, 'Culture Indicators: understanding corporate behaviour', a copy of which is attached separately to the statement. However, further research in our survey report 'Embedding Business Ethics: 2020 report on corporate ethics, policies and programmes', which has been mentioned previously, reveals that fewer than half of large organisations in our survey sample say that their board receives mandatory ethics training -- only 46 per cent; almost a quarter say that ethics doesn't play a part in the board's performance appraisal -- 24 per cent; and a fifth say that matters of ethics are not regularly discussed in board meetings -- 20 per cent.

"Finally, it is also important that there is accountability for the commitment to ethics. Internally and with staff, this can be ensured through the integration of ethics criteria into performance management processes, as described above. Externally,

how an organisation reports on its commitment to ethics and actions taken must be authentic. Companies will not be believed if their communication is spun in a way that simply presents a positive gloss. The introduction of section 172 of the Companies Act 2006 provides boards with a clearer framework for decision making. However, a string of corporate failures led the government to require boards of large companies to report on how they have discharged their duties under section 172. In this regard, companies should be required to go beyond their legal requirements. Our board briefing publication, 'Ethics and Section 172: key questions for informed board decision making' provides practical guidance for boards around making decisions as a group, answers key questions and highlights issues for individual directors to consider. A copy is attached separately.

"In summary, to be effective in embedding ethics into an organisation and align policies and practices, all of the elements described above need to be co-ordinated and sufficiently resourced. If not, the danger is that a gap will develop between what an organisation says it is committed to and what it does in practice, ie, the say/do gap. The wider the gap, the greater the potential for ethical lapses and scandals."

Chair, that concludes the statement of Dr Ian Peters

and I think that concludes the evidence that we have this morning. I'm informed that the witnesses for this afternoon won't be available until 2.00 pm, so with your leave, chair, I suggest we take a slightly longer lunch break and return at 2.00 pm.

THE CHAIR: Thank you, Mr Fullbrook, we will do that.

(12.30 pm)

(The short adjournment)

(2.00 pm)

THE CHAIR: Good afternoon, everyone. Ms Hill?

MS HILL: Thank you, chair. Chair, this afternoon we have three witnesses giving evidence concurrently to provide you and the panel with some context for the evidence that will come later this week.

MS CLAIRE BURNS (affirmed)

PROFESSOR MARGARET HEFFERNAN (affirmed)

MR ED MARSDEN (affirmed)

Examination by MS HILL

MS HILL: I will address my comments to all three witnesses, to start with, please. I hope you can see and hear me all right, but if, at any point, you can't see or hear, then please do indicate. As you know, I will be asking you some questions by following the order set out on the topics list that I hope you have all been sent.

We will go from now until 3.00 pm, by which point we

will have a break. But if, at any point, you need a break before then, then please do let me know.

Please remember to try to keep your head up and your voice up so that we can see and hear you clearly, and try not to speak over each other, although we appreciate that's difficult.

Finally, as far as the topics list is concerned, you will see that there are indications given in blue as to questions that will be aimed at each of you, but if, at any point, you wish to offer some evidence on what somebody else has said and it looks as if I am moving on, then please do just raise your hand, and I will come to you and ask you some questions. I hope that's sufficiently clear.

First of all, Claire Burns, please, can I ask you a few questions, just by way of background. You have provided, Ms Burns, a witness statement to the inquiry with the reference CEL000015. Is that witness statement, Ms Burns, true, to the best of your knowledge and belief?

MS BURNS: Yes, it is.

MS HILL: Chair, with your permission, I adduce Ms Burns' statement in full. Is that all right, chair? Thank you.

Ms Burns, just by way of background, you set out at

paragraph 1 of your witness statement several key features of your professional background, but is this right, that, broadly, your experience in relation to the needs of children and families who are in need of care and protection in Scotland has been garnered through a range of different leadership roles over the last 25 or so years, and you are currently the deputy executive director of Scotland's Centre for Excellence for Children's Care and Protection, or CELCIS; is that right?

MS BURNS: Just one correction there, which is I have recently been made the acting director, due to another secondment.

MS HILL: I'm grateful, thank you. But just in terms of the history, at paragraph 1 of your witness statement, we can see further details of your background that illustrates a long history of dealing with these issues; is that fair?

MS BURNS: Yes, that's fair, thank you.

MS HILL: Turning now, please, to Professor Heffernan, if I may. Professor Heffernan, you have provided a witness statement to the inquiry with reference INQ006360. Is that witness statement, Professor, true, to the best of your knowledge and belief?

PROF HEFFERNAN: Yes, it is.

MS HILL: Chair, with your permission, I adduce Professor Heffernan's evidence in full.

You indicate, at paragraphs 1 through to 6 of your witness statement, that you have a range of different roles. You have worked primarily as an author, writing about issues of management, leadership, organisational culture and ethics, just a couple of the names of books that you have written are "Wilful Blindness", "A Bigger Prize" and "Beyond Measure". You have written for newspapers and journals. You have served as a trustee and board member on many organisations and you are the Professor of Practice at the University of Bath School of Management, and faculty co-lead for the Responsible Leadership programme. You also have experience in the corporate world. Professor, is that a fair, if but short, summary of your background?

PROF HEFFERNAN: Yes, it is. I would simply add I have also run five different organisations.

MS HILL: Thank you. Finally, please, Mr Marsden, you have given a witness statement to the inquiry with reference INQ005330. Is that true, to the best of your knowledge and belief?

MR MARSDEN: It is.

MS HILL: Thank you. Chair, I adduce that statement in full, please, if I may.

Mr Marsden, you are the managing director of Verita Consultancy, which is a leading independent consultancy for regulated organisations. You specialise in carrying out objective investigations of complex and often sensitive issues in a thorough way. You provide organisations with specialist support and advise them on challenging operational and strategic issues in order to help them evolve and improve, and some of the investigations that Verita has been involved with directly relate to child sexual abuse. Is that, again, a fair, but brief, summary of your background, Mr Marsden?

MR MARSDEN: Yes, and other forms of abuse, including adults.

MS HILL: Thank you. Can I turn, then, please, to the first broad topic on the topics list, which tries to bring out some key overarching themes. I will perhaps turn first to Ms Burns, if I may. You have given some evidence in your witness statement, Ms Burns, about the independent review of policy and practice in relation to Child Protection commissioned by the Scottish Government, and I think you indicate at paragraph 12 of your witness statement that national and local leadership was identified as one of the most critical factors in creating a system with effective processes and culture

to ensure children are protected from abuse and neglect. Just help us, please, Ms Burns, a little more with the details around that. Help us know a little bit more about that finding and why it's said that leadership is so important in child protection?

MS BURNS: I think the reason that we know that child leadership is so important is because there are specific leadership behaviours that we know correlate with stronger safeguarding. So if I can just take you through some of them. So leaders who can set a compelling vision based on ethics that everybody can get behind, so, for example, that it's everybody's job to ensure the care and protection of children and adults. They're the people that can ask reflective questions, who can show an interest, can set a culture of curiosity and challenge and role model this. So that becomes even more important in the context of child sexual abuse. They are also people who can undertake and also ensure that their systems have effective supervision and support for the workforce in order to manage the stress and anxiety that's often correlated with sexual abuse.

It's really important, as well, that they are open to multiple perspectives and can hear and integrate feedback and that becomes even more important for our

chief exec leaders and our leaders really at the top of systems who may not have a care and protection background, who may have come from finance or education. So that ability really to hear diverse perspectives. To be open to engage, empower and listen to staff at every level of the system and to children and families as well.

We only know if our policy and our services are working well if we know they're working at every stage and every level of the system, and that children -- and we're also listening to children and families. So one of the things they have consistently told us is, "Your system doesn't respond when I first raise concerns with you. I have to wait until concerns accumulate before you respond".

We also know that leaders need to make sure that there is a feedback loop between them and what's happening at all parts of the system. So do they know from middle managers down to front-line, can they get assurances that the way in which they want the system to function is, and can they look at the data and evidence around that to be reassured?

So we know -- so that's kind of setting the context as to why the leadership is so important. I think, actually, what -- the reason it's really important that

we think about behaviours is we should start to pay more attention to how we recruit and select leaders. Given this set of behaviours, can we recruit to these, can we see they're observable, can we test for these in the recruitment procedures?

I think it's in that context that the Child Protection Improvement Plan said we really needed to look at leadership at both a national and a local level. At a national level, they created the National Child Protection Leadership Group, of which I'm a part. But, more significantly, they were thinking about, "How do we support leaders at a local level, particularly chief officers?".

So what they have developed is a network of chief officers' groups. So chief officers are the chief executives of local authorities and health boards and police commanders who have particular responsibilities and ultimate responsibility for child protection. It's a role where there's historically been very little support to that role, particularly for those who didn't come from, again, a care and protection background, so the aims of those -- the leadership events was to create a network of chief officers, to create a safe place where they could learn and get support from each other. You will have seen from the evidence as well that one

chief officer was able, in a safe space, to reflect on a significant case review where there had been a death of a child, so it was a safe place to be able to talk about that.

Specifically, what they were saying was they really needed help nationally and locally to think about what were the new risks, how could they make sure their protection committees were functioning effectively.

The other thing I will just finish on is to say it was that process that allowed them to really think about what was an action plan for improvement. So action planning and thinking about what was the data and evidence that was required for them to think about whether those improvements were actually having an impact.

MS HILL: Just by way of summary, I think at paragraph 12 of your witness statement you pull together those threads by saying that the purpose of the network you have described is to share good practice and collectively horizon scan for new risks facing children and young people, and you have given some further detail at paragraphs 13 through to 20 of your witness statement.

Is there anything else about the utility of the chief officers' leadership network or events that you would like to add?

MS BURNS: One other, which is an update from when I did the expert witness account, is one of the additional asks they had was for really good induction materials, particularly for new chief officers. So that's something that's been developed. It's covered issues such as, again, what is their role and function, what does it look like for them to dispense their responsibilities well. It's also looked at how do the range of committees integrate with each other and, again, seminars on what are some new risks around, for example, domestic violence, drug and alcohol issues, so, again, bringing up these kind of emerging risks as well.
MS HILL: For completeness, please, I will adduce the Child Protection Improvement Programme that you have mentioned, Ms Burns. That's got URN reference CEL000001. For the note, can I bring up within that document briefly on screen, Danny, internal page _049 on our URN, which is the report internal page _048. This improvement programme, Ms Burns, had a range of themes, but one of the themes it brought out was the need for leadership and workforce development. The chair and panel can perhaps read those key messages on page _049 and over into internal page _050, which talked about the actions that flowed from that.
We can then also just perhaps note that there are

within that report -- we don't need to bring it up -- at internal page _065, a leadership and workforce development map that may be relevant to the chair and panel.
Is there anything else from this document itself that you would like to draw out, Ms Burns?
MS BURNS: I think just one additional point is that I think, even since then, we are learning a lot more about the facts that we need to bring in. We often just have this for leaders who we automatically think are involved in the care and protection of children, so from social work, from health and education. I think we're learning a lot more that, actually, some of the decisions around what happens around resources, for example, directors of finance, directors of commissioning and procurement, they often hold the power and the leverage in the system, so when we're thinking about networks of leaders, we need to think much more broadly than we do at the moment and about who are the other people who are making decisions about children's services.
MS HILL: Finally, Ms Burns, before I come to the other witnesses who are here, at paragraphs 21 through to 32 of your witness statement, you pulled out some further themes around, for example, the fact that child sexual

abuse is often hidden and the concern to make sure that denial as an issue does not seep into leadership.
Do you want to tell the panel a little bit more about that part of your witness evidence and what can be done to mitigate against that risk?
MS BURNS: Yes. So in relation to -- I think those are the -- there's adaptive technical and adaptive activities that we need leaders to do. So we need to make sure they have the correct procedures and processes in place, but we also need for them to think about what are the other issues around lost power, denial around -- particularly around child sexual abuse. We need them to feel confident and competent so they have access to the up-to-date evidence, they've got access to the up-to-date data, that they feel comfortable about being upfront about talking about child sexual abuse, that they, themselves, know what are some of the signs of that so that they can then -- they're gaining assurances throughout their system as well that that's what's -- that's getting paid attention to.
Again, later on in the evidence, you will see there is some concern from us that, with other emerging risks, such as child sexual exploitation, that it's seen quite separate from child sexual abuse and, as we focus on one thing, we lose a focus on another and, really, for our

leaders, it's about saying we need to keep a hold of all of these risks at the same time and also because they don't happen in isolation from each other.
MS HILL: Thank you, Ms Burns. Mr Marsden, can I just ask you some questions now about the introductory part of your witness statement. At paragraphs 3 through to 17, you describe several of the investigations that have been carried out by Verita. You refer to the Jimmy Savile investigation and to several other investigations, particularly in the healthcare sector, and also involving a political party.
In relation to those investigations, what key leadership failures and lessons learnt do you think we can draw from that experience that your organisation has had?
MR MARSDEN: When it comes to Jimmy Savile, I think he, you know, made his sort of entrance to the NHS in the '60s when management structures were almost non-existent, and, you know, that gave him, I think, an opportunity to exploit the organisations that he had an association with.
Eventually, you know, he does get, you know, opportunities provided by other managers to go to places like Broadmoor and work there. I think his behaviour is eventually challenged by the advent of Trust status at

Stoke Mandeville, where he was very powerful in the National Spinal Injuries Centre, and the arrival of the Trust structure, you know, in the NHS leads to a chief executive eventually challenging him about his behaviour and his status and standing in that particular organisation. So it sort of rather underlines the importance of leadership and it began to sort of dent his position in that particular organisation.

MS HILL: Just before you leave that issue, can I bring up, please, on screen, Danny, within Mr Marsden's witness statement INQ005330_002, paragraph 5. Mr Marsden, can I just zone in on what you said at paragraph 5, some key themes you have drawn out there. Your key findings included: those intent on abuse will try to access hospitals or other care environments; hospitals are an attractive environment to abusers; organisations have a continuing weakness for celebrity/people in positions of power; challenging those in authority is not easy; and the management of volunteers is a particular issue.

Do you think those are leadership issues of generic application in this field?

MR MARSDEN: Yes. I think there are other things that I would say have come out of our work about -- well, themes about failings in organisations, so Trust boards or boards of organisations ignoring early warnings that

things are going awry; non-executive directors not being sufficiently inquisitive about things that they have perhaps been told at a board meeting; organisations applying short-term fixes with adverse long-term implications. I suppose, you know, Oxfam is a very good example of that, although it is not in our case book, so to speak.

I think, in the case of Ian Paterson, there was a lot of evidence to say that managers fell short in their management of him because of his persistence and determination to do the things that he wanted to do, you know, as a surgeon. I think there's a continuing trend of organisations not sharing information, not being good citizens in their sectors, if you like. So, "I know your front door is open, but I'm not going to tell you". I think we still see quite a lot of that behaviour in organisations; victims sometimes being, strangely enough, supporters of people whose behaviour might be in question -- David Britten is a good example of that. And a very powerful piece of evidence from a recent case that we have been involved in is, healthcare professionals not believing that a colleague could abuse, even after, you know, a conviction, but finding it really difficult to accept the idea that someone could be, you know, so malign as to commit a terrible

offence.

MS HILL: The chair and panel can read, in due course, through your witness statement you have given further details about the investigations into David Britten, Myles Bradbury, Ian Paterson and then also the Green Party you have described.

Is there anything else arising from what Ms Burns has said on these topics, Mr Marsden, that you would like to comment on?

MR MARSDEN: No, I don't think so.

MS HILL: Professor Heffernan, you have heard the evidence given by both of these two witnesses on this general topic of the importance of leadership and the key themes arising from leadership failures. Is there anything in particular you would like to add?

PROF HEFFERNAN: I would add a couple of things. I tend to think of leaders of organisations facing in two different directions. They have to focus inside their organisations to do a number of things. They need to ensure that there is real coherence across multiple disciplines. Very often in organisational life, each department, each discipline, is its own empire. They're often competitive for resources. They often speak very different languages and attract very different kinds of people, and ensuring some coherence in purpose and

standards across those groups is a really fundamental internal job, if you like, of leaders.

I think it is also important that they ensure that the goals for everybody in the organisation are appropriate goals, and that the incentives that may or may not be attached to those, or indeed threats that may be attached to not achieving them, are fair, realistic and appropriate.

I think they need to be extremely circumspect on the use of targets, which, especially if attached to threats or incentives, can become very, very distorting of people's decision-making capabilities.

I think they need to ensure that their organisation, or their part of the organisation, has the resources it needs to do what the organisation has committed to do. So where, for example, the organisation has made commitments to certain standards in a volume of work and there simply aren't enough people to do that work at a respectable standard, that would be a failure of leadership.

Equally, ensuring that the people concerned have the time they need to do the work that they're committed to and the time they need in a fit mental state. In other words, we understand very clearly now how people's professional performance degrades with exhaustion or

distraction, working in places that are distracting or having to multi-task. So it is absolutely a prime leadership responsibility to ensure that the commitments the organisation have made are amply and appropriately and healthily resourced.

The last part of this kind of internal job, I think, is to ensure that the people working in the organisation feel safe, they don't feel in a persistent state of threat, and that, therefore, it is a safe and indeed expected part of their work that they will speak up when they feel that any of the things I have just mentioned aren't actually functioning as well as they need to.

I think that, you know, good leaders have to be very clear about who is accountable for what. Everybody can't be accountable for everything, or you just get an internal fog.

Then I think there's an external piece of leadership, and the first is about ensuring that the standards and knowledge base of the organisation are up to date, so that the organisation isn't falling behind in terms of external research and understanding and that the organisation is appropriately connected to the society that the organisation serves. In other words, it's in tune with standards and expectations of the organisation, because these things are socially

generated and they change. So they need to be in tune with what people expect of them and how people view what's good enough versus what's a failure.

I think they have a really fundamental task in terms of what I think of as horizon scanning, which is constantly thinking, does the work, does the organisation feel right, does this feel like a productive, safe place to be, does it feel like it's really up to date and current and part of society, as opposed to isolated from it?

MS HILL: Thank you very much, Professor. I move on now to the text topic on our list which is that about embedding ethics and values so that they align with policy and procedure. I think you have all been provided with some evidence that -- in fact, part of it has been read to the chair and panel this morning. That is evidence from the Institute of Business Ethics. Just to adduce some of the documents, one of the issues that the witness Dr Peters from the Institute of Business Ethics talks about is how an organisation's ethics can be embedded into its decision making, and I will bring up, please, on screen, if I may, IBE000007, which is the good practice guide from the Institute of Business Ethics to ethics in decision making. Just perhaps to pull out for the panel some key parts of this, if we can go, please,

to internal page _007 and scroll in on the box at the bottom of that page, "The IBE's definition of business ethics":

"... the application of ethical values, such as integrity, fairness, respect and openness to business behaviour."

It goes on to talk about business ethics being about how an organisation does its business and how individuals carry out their roles. Then if we go over the page, please, Danny, to internal page _008, there is a framework for considering ethics in decision making. If you scroll in on the little diagram, underneath that you will see it has four elements of ethics in decision making: context and culture; rigorous reasoning; an ability to apply decisions; and reflection.

Just finally on this, as part of that third piece, the ability to apply decisions, can I bring up, please, internal page _012 and scroll in on table 1, which the chair and panel might wish to look over. This was the result of a piece of work to identify the top factors that were most likely to cause people to compromise an organisation's ethical standards. They can see on that list different factors, including things like desire to further one's own career, pressure to meet unrealistic objectives or deadlines, desire to protect one's

livelihood, improper training, diminished morale, lack of consequence if caught, need to follow boss's orders, peer pressure, desire to steal from or harm the organisation, and, equally, wanting to help the organisation survive or a sense of loyalty. Those sort of themes.

We can take that down, but, broadly, that is the guidance given by the Institute of Business Ethics about how to embed ethics in decision making. On a similar topic, evidence has been given about the purpose and utility of codes of ethics and about how to communicate ethical values. Just before I come to the witnesses, we will perhaps just bring up, please, IBE000012, which is a document about how to communicate ethical values internally.

If we just go perhaps briefly, Danny, within that document to internal pages _010 and _011, there is a certain amount of information in there about communicating ethics, about -- we heard from the read evidence this morning I think a little about this, but the Golem effect and the Pygmalion effect are all set out there. The chair and panel can read further on this if they wish. There is perhaps one other part, if we can go back to internal page _009, one of the ethical issues that was brought out at the bottom of this page

was the concept of the bad apples, if you like, where there was an explanation given, "Well, it is just a few bad apples", and the quote goes on to say:

"It is not just a few bad apples, it is actually the barrel in which they are operating and we need to fix the barrel as well as track down the bad apples."

That's just one of the examples given here. Pausing there, can I ask, please, Ms Burns, first of all, do you have any observations on this pool of evidence from the Institute of Business Ethics that I've summarised quite briefly there, but I hope doing fairness to it? Do you have anything that you would like to add on these principles?

MS BURNS: Just quickly, I think, to say that the starting point of ethics and values is absolutely right, and then we are working within the organisation to look at improvements. That's where we start, as we start with, "So what are the values and principles that you're trying to embed into the system?". What I would say to you is, though, it's essential but not sufficient to get changes in practice and that's where we need to see it. We need to think about, how do we translate those ethics and principles into what we actually want to see people saying and doing? We need to be able to say -- when I see that behaviour, when I see staff saying and doing

something, I therefore know that that ethic has been embedded into a practice and that there's a feedback loop to tell leaders that it's happening. We often hear people talking about, "We need culture change", and then people think, "Well, what brings about culture change?", but culture change is actually, when people start to do and say something different, you get a change in the culture of the organisation. So I suppose my point would just be that they are an essential starting point but will not be effective unless we can actually translate those explicitly into what we are expecting people to say and do so that we can recognise it, we can measure it and we can coach to it as well.

MS HILL: One further document I will ask you to look at, Ms Burns, and bring up, please, for the chair and panel, this is the ethical business leadership document, "Setting the Tone", IBE000002. This is really about the role of leaders in modelling ethical values and setting the tone. If we can go, please, to internal page _009, Danny, the executive summary I think fleshes out some of the themes. If we just look at the questions and the answers just very briefly, the question on the left is:

"Why is ethical leadership so important?"

There's an answer given, but the bold is:

"A leader's influence extends beyond the company

itself."

It goes on to talk about the role of leaders in -- just looking at the bold on the left-hand side -- influencing the internal tone of an organisation. Going over the page, the influence of stakeholders and society as well. This is part of a much wider report about the role of leaders.

Ms Burns, is there anything else that you would like to add on that topic of what part leaders play in modelling ethical values and setting the tone?

MS BURNS: Yes, I think particularly in the context of child protection, it's how do they set -- it's the way in which they set a compelling narrative that people can get behind, it's often by the use of values and ethics. I think it's about reinstating for staff, often, the reasons they first came into social work or health in the first place that they often feel has been let go. So about supporting families, supporting families where there are difficulties, where there are challenges, about being able to work with them in a way that is trauma informed that helps them get over some of the challenges they face. So I think the statement of ethics and values is about how you get your workforce to really invest in your vision, in your statement, because I think that's often why they came into this work in the

first place.

MS HILL: Thank you very much. Professor Heffernan, is there anything you would like to add on these broad topics about embedding ethics and values, communicating them and the role of leaders in this field?

PROF HEFFERNAN: Yes, just a couple of things. First of all, I think, of the many organisations I've researched and worked in and worked with, I would say that it's very hard to tell when ethics are embedded. You get a lot of posters and a lot of seminars, and I think, in many instances, people regard this as formulaic, banal, meaningless, not relevant to them.

The second thing I would say, connected to that, is, we really do understand that ethical thinking is cognitively expensive, which means that you have to be rested, you have to have time to think, and to think clearly, and so, when people are overtaxed, both in terms of their professional work and maybe their family demands, we know from research that people will simply not see that something that is being decided or being done has any ethical dimension. Most people don't understand ethics, ethics are not taught in organisations. What an ethical decision or choice looks like, most people are quite poor at identifying. So I think, in most organisations, the depth of ethical

thinking and consideration is painfully thin. You know, to call it icing on the cake would give the impression it's actually thicker than it is. So it's talked about but my experience shows me nobody really knows what anybody is talking about, so they don't really take it seriously. Very few people can really identify ethical moments in decision making.

I would also say that whether or not ethical decision making becomes the norm in an organisation depends crucially on the diversity and the leadership in that organisation, which is that if it's all run by people who are roughly the same, roughly the same background or gender or ethnicity or discipline, or whatever, then there will be a failure to take perspectives, because, you know, my ethics aren't the same as yours, they aren't the same as my neighbour's, they aren't the same as my children's, and so ethical errors often occur when what I think is good you think is not, and if we don't have diversity in decision making, we may miss ethical problems because, to us, the situation seems fine, whereas to a different group they might seem deeply problematic. That's not about political correctness; it's understanding that ethics are intrinsically subjective. However rational we may be in thinking and talking about them, they are

nevertheless subjective.

I would also say that it's really crucial in ethics to find a language to discuss ethical issues which people understand. It's often surrounded by jargon and abstract nouns. You know, you have pages of abstract, you know, vague, undefined concepts which mean nothing to people. If you are going to talk about ethics, you have to talk about situations in which choices have to be made, and who is thinking about whom, and that's rarely the kind of gritty, realistic, recognisable detail in which ethics is discussed.

Two other quick points. I remember in the Savile Inquiry into the BBC, Dinah Rose QC made a list of recommendations, one of which was she urged the BBC to go out of their way to recruit individuals with high ethical standards. There is no blood test for high ethical standards. It is impossible to identify who has high ethical standards and who does not. So I think the notion that you have to have particularly good people to make good decisions is at least completely impractical.

The last thing that I would say is that, as much as we talk about leaders as though they really have control over their organisations, the truth is that you don't, because the organisations inhabit a wider society, and I might, as a leader of my organisation, wish it to

conform to a certain bunch of ethics, but if the social pressure is against those, then I really have no chance of absolutely changing the way that the people who report to me think.

If, for example, you are working through a period of very high unemployment and very, you know, extreme economic decline, the pressure exerted by that much bigger context will override a great deal of so-called ethical management, and so I think it is important to understand that no organisation exists in a vacuum. It has all the multiple ethical perspectives of each person working inside them, and it has all the external pressures about public mood, sentiment and economic condition, and that's part of what makes leadership so immensely complex.

MS HILL: Thank you, Professor. Mr Marsden, anything else on this topic that you would like to add that's not been covered by your fellow witnesses?

MR MARSDEN: Yes, if I could. Carrying out the Savile lessons learnt report for the Secretary of State, Kate Lampard and I visited a lot of Trusts and I would say almost all of them had carried out work on values and, you know, what does this organisation believe, and, as Professor Heffernan said, perhaps done a lot to communicate those values down into the organisation, you

know, questionable, I think, how much notice people really took of them.

Addenbrooke's is an organisation where Myles Bradbury worked, a large established teaching hospital with values and mission statements and no doubt, you know, safeguarding leads and managers galore, policies galore, but I don't think any of that would have stopped Myles Bradbury from what he did. Perhaps that's another bit of evidence, but I think you have to have those things and they're really important, but, as Professor Heffernan says, the sort of -- the impact of them, in the end, is sort of questionable, but you have to have them, and you should have them, but they won't necessarily prevent things from going amiss.

MS HILL: Thank you, Mr Marsden. While I have you, if I may, I'm going to move to the third topic and ask you some questions about some of the key lessons that you've drawn out in your witness statement at paragraphs 18, in particular, through to 24, but also, in fact, through to paragraph 31.

If I have put this correctly, I think the three key themes that you have drawn out from the investigations that you have carried out are, firstly, you describe the "someone else's problem" phenomenon, people seeing safeguarding as someone else's problem; second, you talk

about safeguarding issues being associated with particular patterns of behaviour, and you've mentioned there the concept of superhero status; and then, thirdly, you have talked about a particularly worrying theme of organisations prioritising their short-term reputation over safeguarding.

Those three themes all, perhaps, to varying degrees, feed into this topic of how organisations can stay safe and be effective at being safe. So would you like to just amplify those themes a little bit or help us understand a bit more what you mean about these three different themes?

MR MARSDEN: Could I start off by saying something about the behaviour of the individuals who feature in our case book, the cases I have referenced in my witness statement? Those individuals, all of them, share some common characteristics: one, they are very persistent, you know, in their intention of getting their own way; they share the characteristic of being manipulative -- certainly that was true of Myles Bradbury, but also of Ian Paterson and David Britten; and I suppose the third characteristic that I think is a real challenge for organisations is, they're very highly motivated to get what they want, and they're more motivated to get their way than organisations are to stop them.

They do share some behaviours that I think provide a sort of breadcrumb trail, if you like, to help with their management.

All of those individuals -- Bradbury, Britten, Paterson -- sought to create in their patients, you know, dependent relationships. So where you see me as the person who is your saviour, you know, "I'm going to cure your cancer" or, "I'm going to make your child better from the cancer that they have", or, you know, "I'm going to help you overcome your eating disorder", and they use that relationship to, you know, exploit people, and other professionals -- I think this is true of Addenbrooke's and Myles Bradbury -- sometimes get drawn into thinking along those lines, and question their own abilities and their right to challenge.

The second characteristic that they share, which I think is worth drawing to your attention, is, they create the space to operate, and particularly, you know, in the case of Bradbury, say, to abuse, and that can manifest itself in unorthodox working practices. So Myles Bradbury would choose to see patients out of hours and do that in order that he could abuse. People ascribed good motive to that: they thought, "He's a good doctor and he's doing that for benevolent reasons". But this practising alone, you know, is a real clue, along

with other behaviours, particularly sort of unorthodox working practices and seeking to create that dependent relationship, I think a real clue to these people's behaviour.

MS HILL: Forgive me, those are clues that you have described in your witness statement as being things that managers and colleagues should be quicker at picking up as patterns of behaviour.

MR MARSDEN: Absolutely. I think there is something to be said for actually in the NHS, for example, teaching staff about those behaviours. You know, it's not that you should challenge the lone worker, because there are plenty of lone workers in the NHS who are doing a proper job, but it is that bundle of characteristics that provide us with a clue to people's intentions, and those, I think, do need to be more explicitly taught.

In fact, we have had discussions with NHS England in the last year or so about actually doing some work along those lines, and I think it would be really worth doing.

The question of sort of other response -- you know, who is responsible for safeguarding, I think that certainly in the Green Party I don't know that it was very clear from that investigation who was responsible for safeguarding in the Green Party. I think it is clearer in, you know, bigger organisations, and one of

the things I would say from the lessons learnt report that we did into Savile was that probably most NHS organisations had made a lot of progress in terms of who was responsible in the organisation for safeguarding and how was it enacted.

MS HILL: I think the broad theme, to pull the threads together that you bring out of your "someone else's problem" piece of your witness statement, is you say that experience tells us that breadth of knowledge in an organisation is as important as its depth. The message, therefore, should be akin to that in relation to terrorism, you say: if you see something you think isn't quite right, tell someone about it. Safeguarding is not something that can be left to the experts.

MR MARSDEN: No.

MS HILL: On the final topic of prioritising, in the short term, reputation over safeguarding, you believe the important message there is to convey to organisations the unacceptability of that prioritisation. Have I just pulled out the key themes on those topics correctly?

MR MARSDEN: Yes, and I think that theme of organisations not being good citizens is one that we continue to see, and I think it absolutely requires challenge.

MS HILL: Professor Heffernan, can I come to you, please, to give us your views about this issue of how to ensure

that leaders and staff do take personal responsibility for safeguarding, avoiding what I think has been referred to as bystander behaviour. Can you give us your views on those topics, please, Professor?

PROF HEFFERNAN: Yes. I think in many complex organisations, it can become very murky as to who is responsible for what, and I think there are two issues here. One is, people often go to great lengths to ensure that they're very clear about what they are responsible for in terms of delivery of work, so they know what their deadlines and goals and targets, and so on, are.

Where things are more diffuse, and safeguarding is a classic example, where safeguarding may be the responsibility of one person but it is also a general responsibility of all persons. That's the point where people's sense of what their professional standards are gets very confused. It can even get to the point where everybody knows this and everybody recognises that there are difficult things that nobody really wants to handle, and you can even get a situation where this becomes a kind of a joke.

So one example of this would be at General Motors in the United States when one of their cars had a known fault which in some cases causes death, and yet, within

General Motors as a whole, there was a great joke, and this is reported by Anton Valukas who did the investigation into General Motors. Everybody made a great joke of the fact that nobody wanted to touch anything difficult, so they had what they called the GM salute, which is, if you say, "Okay, who owns this?" or "Who is going to run with this?", executives would cross their arms and point in opposite directions. In other words, "I'm not doing it, you're not doing it. Ha, ha, ha, isn't this hilarious?", and that can become culturally quite embedded. Nobody called it a person's salute, they called it the General Motors' salute. So you can get a kind of culture where everybody knows what the hot potato is, everybody knows not to touch it, everybody will make jokes about the people who try to touch it and often kind of expel that person -- that's what you saw at Bristol Royal Infirmary when the anaesthetist, Steve Bolsin, tried to raise concerns about a dangerous surgeon.

So, you know, there is a political sensibility in organisations around work that's difficult that nobody wants to do, and so, often, the fact that it isn't being done is widely known and often even celebrated. You know, the people who manage to dodge the bullet, you know, it's seen to be a sign of political prowess.

So this is about bystander behaviour, in the sense that sometimes it is very conscious and slightly self-serving, but sometimes there's simply an assumption that, well, this is so widely known, it is such an obvious and visible problem, that clearly somebody must be doing something about it. It couldn't possibly be the case that nobody would be doing something about it.

So there's an operating assumption that, "I don't need to do anything because clearly somebody is doing something", and that creates a kind of vacuum in which, you know, everybody may -- (a) everybody has a sense that it is well known; they may also feel that talking about the problem among themselves is a form of action, when, in fact, it isn't.

So if I'm concerned that there is something difficult going on and I talk to my colleague about it over coffee, we feel we have done something, but in terms of real action that produces an outcome, we haven't.

So my work around wilful blindness is about these situations in which everybody knows, people may even be talking about it in the canteen, as again was true in Bristol Royal Infirmary. People have a sense of, well, it's such public knowledge, something must be happening, when, in fact, nothing is happening.

MS HILL: Can I just bring up, Professor, while you're on that topic, in your witness statement, INQ006360_001-002. If we can scroll in on paragraph 7, Professor, that straddles both those pages, you talk there about the concept of wilful blindness about which you have written. You describe there this as being a recurrent phenomenon in individuals and institutions where some ethical wrong is persistently overlooked by those who bear responsibility or those who are threatened by that wrong:

"I kept seeing the same pattern emerge after each organisational failure. First, everyone said nobody knew or could have known. Then it transpires that a few people knew and tried to do something but which silenced, ignored or punished. Then it turns out that just about everyone knew that there was a major concern."

Does that reflect the phenomenon that you are talking about?

PROF HEFFERNAN: Yes, and, I mean, these cases crop up in the news on a kind of regular basis. The Volkswagen emission scandals would be another one. They always follow the same narrative, which is, "Gosh, no-one knew", and then, of course, there is always someone who knew, and almost invariably someone who did try to at

least pose an argument as to why this was a bad idea. Certainly in the mortgage crisis, in the financial crisis, this was true in really every financial institution that I talked to, a very pervasive sense in every part of the organisation that these were dangerous products that were bad for people and bad for the financial system. So this narrative that, "Well, nobody knew. We couldn't possibly have seen this", to "a few people did know" and then evidence that people not only did know but tried to do something about it, to the sense that, actually, everybody knew, this is the narrative that many, many, many of these cases follow.

MS HILL: Thank you, Professor. Just finally, Ms Burns, in the last few minutes before we take our break, in your witness statement at paragraphs 58 through to 64, you have talked about leaders trying to close the implementation gap between initiatives and policies and actual changes in practice on the ground. Perhaps with a particular focus on how organisations can be safe and effective at being safe, is there anything else that you would like to add on that topic or what you have heard from your fellow witnesses?

MS BURNS: Just a couple of points. I think there's comparisons that can be made with what Professor Heffernan is saying and bringing that into the

context of child protection. In my evidence you will see we talk about this missing middle which is where there's no capacity or response when early concerns are raised either by a family or by workplaces around a family.

So in terms of this missing middle, what we are hearing is that health -- other -- universal services were saying, "This situation is actually too difficult, too challenging, for universal services, it is not for us", and you have statutory social work saying, "They have not quite reached the threshold, it is not quite serious enough for us". I think there are comparisons to be made there.

In that missing middle, then, you need new functions. If we are going to develop early family support, which is a lot of the values and statements that local authorities will say, I think, again, the evidence that Professor Heffernan gave before is, what we tend to do is we then tend to either layer it on to somebody else's responsibility, so that's -- and that's the first one, so it is just an additional responsibility that somebody has got.

I would really like to, in the last couple of minutes, focus in on my evidence around the implementation gap, in that we are always really

disappointed that we don't shift the outcomes with a range of initiatives that we try to implement, and I would say that one of the most important things for the committee to consider is that we don't pay enough attention to the evidence around the how of change as well as the what. We often think, if we can identify the right intervention, that's going to be sufficient, so something like family group decision making or significant case reviews. It's not sufficient. We all, as a sector, have very strong mental models around what will make change happen that the evidence doesn't actually support us on. So things like legislation and guidance. So, in Scotland, we have seen a plethora of legislation and guidance. Again, it tends to just layer on and clutter the landscape for the workforces and complicate for them. We have websites, we do guidance, we do train, training the trainers. These things are essential but not sufficient to get the changes on the front-line that we want and we really need to start paying more attention about what are the conditions and the supports that are required by the workforces if we want to see the aspirations in legislation and guidance really be put into practice. One of them is that we have to put in data that measures those practices and says that people are practising as was intended and that

they're also having the outcomes as intended.

MS HILL: When we return after the break, I will ask you some more questions about management information and some other topics, but, chair, it is 3.00 pm, so could we perhaps take our mid-afternoon break and return at 3.15 pm?

THE CHAIR: Yes, we will do that, Ms Hill. Thank you very much.

(3.00 pm)

(A short break)

(3.15 pm)

MS HILL: Ms Burns, just before we broke you alluded to the topic of management information, so I will just take topic 6 on the topics list if I may now, please. You have given some evidence at paragraphs 33 to 41 of your witness statement about the approach taken with the minimum data set for Child Protection Committees. If I can just bring up the guidance document, please, CEL000011. This is a guidance manual produced last year by CELCIS. If we go, please, to internal page 3, can I just ask you to help take us through this. If we can put pages 3 and 4 side by side. Ms Burns, if I have understood it correctly, what you have set out here in the guidance document are 17 different sources of data. So, in fact, we can put page 2, please, on one side and

page 3 on the next, Danny. So it is the table of 17 factors, so it is _005 on our numbering but it is page 3 of the document.

On this table, Ms Burns, if I have understood it correctly, there are 17 different indicators which are different types of data. I think the broad thrust of the guidance here is that, through consultation and development, these sources of information are considered to be the minimum data set for Child Protection Committees. Have I broadly understood that correctly, Ms Burns?

MS BURNS: Yes, you have.

MS HILL: Just help us in understanding a little bit, please, the significance of this management and order information and why you think it is important for child protection issues?

MS BURNS: I think the first general statement is about the fact I think data and the use of data is a real leverage point in the system that we don't maximise. So it is a game changer in how we do children's planning if it is done well. There is currently insufficient focus on data generally that helps us with children's planning, with responding to the needs of children and families because we don't have the confidence or competence in the sector within leaders to look at it, or the

technical skills. We also don't have good data systems that allow us to pull the data out that we need or to read across systems as well.

To give you an example of this, when we were working on our workaround improving permanence for children and we were looking at key decision making and the delays between decision making, we had to go to individual children's files to find those out. So still, even today, we don't have a system that really helps us to get easy access to the data that we need.

In terms of the minimum data set for child protection, it was: what is the most important pieces of data that we need to be able to do children's planning? So, again, there are lots of data sets. It was often what leaders were seeing as -- it was really difficult to see the wood for the trees within them, so how could we help them think it, what was it they really needed to focus their attention on that would allow them -- to help them do their planning kind of internally and on a local basis, but would also help them to benchmark nationally as well. You can see from the others a range of indicators which includes numbers, characteristics of children and families, whether they have been registered or not, other contextual factors, timescales between different decision-making points which are important and

also parental involvement as well.

I would just say that, you know, we are also trying to do this in a way that is aligned with what I've been saying around the implementation gaps, so we were saying guidance alone wouldn't be sufficient, training alone wouldn't be sufficient. So we have done these things that we are providing regular support at a local level on an ongoing basis to the pilot sites and I think that's been part of the success of that.

So it has allowed them to look at the data around their children, but it's also allowed them to look at the effectiveness of the systems around those as well.

One of the local areas was saying what was really helpful about it was, it streamlined their reporting, and it also, again, really helped them to focus in on what was the most important data that they needed to pay attention to, and then, again, it helped them think about what was an action plan for improvement and what would be the measurements to demonstrate that they had actually implemented those improvements.

MS HILL: Just one example of something a bit more granular that might affect particular children, you have given the inquiry a copy of the Care Inspectorate practice guide to chronologies. Can I just bring this up briefly, CEL000012. I think this document takes

practitioners through understanding the importance of chronologies around children. We can go and look, please, on internal page _003, Danny, just so the chair and panel can see the sort of detail that this document goes into. It sets out a series of things that will help practitioners make sure chronologies are more useful, and that's one example of accuracy in data that perhaps has a particular impact on specific children. Is that fair?

MS BURNS: Yes. I think the significance -- again, the issue with chronologies, again, is similar to data. Often, either the worker, whoever the worker or lead is, it's really difficult to see the wood for the trees again, in terms of what has been the significant events or the significant timescales or family circumstances that's required for us to make good assessments and do good planning, and, again, often workforce -- key workforces will say to us, "Just tell me what you want me to write in chronologies" and we say, "No, it is actually about saying: how do you pull out the correct information that allows you to make an assessment, that allows you to do the analysis? So it can't be totally prescribed. It is the skill of analysis and assessment, that this gives the framework for it. It's really important in terms of child sexual abuse as well because

we are often working without a disclosure, so we are having to look behind some of the behaviours that are happening with the child or the young person. So, again, getting these factors, pulling these factors, together is really important. Again, often what we do is we think about chronologies at the point where something chronic has happened or where we're thinking about taking a child into care or making a decision about permanence and, actually, one of the things about chronologies that we need to be more intentional about is, how do we use them at a much earlier stage to aid planning for that individual child and for their family?

MS HILL: I'd like to move back now, Ms Burns, to the related topic within your witness evidence about the value of seeking and listening to the voices of children and families. You indicate at paragraphs 56 to 57 of your witness statement -- if you just perhaps pull up CEL000015_012-013, which talks about the need to strengthen children's voices and participation. You have provided evidence at paragraphs 56 to 57 about that, Ms Burns. Is there anything in particular that you would like to draw out for the chair and panel from that evidence?

MS BURNS: Again, I think across the sector there's a real recognition that this is something that we should be

doing, it's an ethical issue, it upholds young people's rights. It's a real safety mechanism for children and young people as well, that if we open up dialogue then, if things have happened to them or they have experiences they need to share with another adult, it gives them a way through.

It also ensures that we are making a holistic assessment of what's happening because that child and young person will have their own kind of valid experience of family circumstances.

So I think, you know, most of the sector is onboard with the fact that this is something that we should be doing and we ought to be doing. Again, this will be subject to some of the difficulties that we have talked about in terms of implementation more generally. In Scotland, we have just had a review of an independent care review which was predicated on the views of children and young people and their families, which I think has been hugely positive, and there is a -- it's clearly anticipated in that that this is something that participation and voice is something that will be embedded in local authorities going forward. I would argue, again, asking people to do that and providing guidance to do that will not be sufficient, they will need support. It's also incredibly skilled work. What

we have learned as well is that children and families need support both before they go to a particular meeting, child protection meeting or a hearing, as we have in Scotland, they will need support during it and they will need support after it as well, from people who are trauma informed and can manage that.

So it is not something that anybody can do. So I think, again, a real commitment in the sector to see that work move on. It will take support for workforces to do that.

I think where we need to pay attention is particularly around more marginalised children, so disabled children, children who are engaged in the criminal justice system, and particularly thinking more and looking at the evidence more around voice when it comes to babies. So what is it about babies and infants, what is it about behaviour that's telling us something, even though, verbally, they can't participate.

MS HILL: Just to adduce, please, the independent review of care that you have described, it is referred to as "the promise", CEL000014.

If we just perhaps bring up that document, Danny, it's CEL000014. If we scroll to _003, Ms Burns, you have provided this document which indicates -- the

thrust of this document being Scotland's promise around a series of topics, but a significant focus is given to the topic of voice, and we can see, if we look internally, please, at pages _030 and _031, have them side by side, please, this summarises, I think, the findings of the review, about the need to ensure children are listened to and meaningfully involved in decision making about their care.

Then, perhaps, on a more granular level, if you go, please, Danny, to _033 and _034 and put those side by side, that gives a series of bullet points, Ms Burns, underneath the heading "The way Scotland listens to children, families and the workforce must look vastly different". I'm just pulling a few of these topics together now, but on the topic of speaking up, in terms of members of staff and the workforce, is there anything that you would like to add around that and the role of leaders in particular in encouraging a speak-up culture? That's perhaps the voice of staff?

MS BURNS: Yes, absolutely. We will talk about important voices from the front-line, and then we're talking about the front-line, we are talking about children and families and we're also talking about the workforce as well. We need that openness, again, particularly in the context of risk and protection, so the way in which

there's an openness in supervision to be able to talk about things that staff are worried about, but also just an openness generally in the system as well; in what ways is the system open to hearing those multiple perspectives and in what ways is it open to hearing about challenge as well?

Also, we also know that any intervention that we try and implement in the system will only work as well if we have got those feedback loops that I talked about from all parts of the system, because we can have a good idea but, actually, it will be front-line staff that will know what are the barriers that still need to be unlocked for that to have an impact as intended, and what else is it that leadership need to do to be able to flex the system around that.

MS HILL: Finally, Ms Burns, before I turn to your fellow witnesses, you were asked under topic 4 to look at some witness evidence from the Children's Society, from Barnardo's and from the Children's Commissioner. Those particular paragraphs that were flagged for you in their witness statements, is there anything you would like to say in relation to those paragraphs that you disagree with or agree with or that you would just like to comment on?

MS BURNS: There is nothing additional, no. I think the way

in which we think more intensely about those most marginalised children and I think we have a group of children who are skilled in Scotland now and are used to giving their view, but it needs to be much more holistic.

MS HILL: Can I move now, please, to Professor Heffernan. Professor, you have heard me ask questions about those three broad topics, so just by way of reminder, they were about using management information, about achieving openness and listening to the voices of children, and about achieving good communication and escalation of issues by employees. On those three topics, Professor, is there anything that you would like to add?

PROF HEFFERNAN: The only thing I would say is, I think it's actually very difficult to create what has come to be known as a speak-up culture, and that's because, however one may create an environment in which that's expected within an organisation, it comes back to a point I made earlier, if the individuals working in that organisation carry a high degree of personal debt, for example, have very large mortgages, if we are living through a time of high unemployment, there is an implicit sense of threat, and leaders in organisations need to be very alert to that. However much you say -- and I have had this experience myself -- "I will never shoot the messenger.

My door is always open", by and large, people don't believe it because they have never seen it. If they feel vulnerable in terms of their financial or professional position, it's -- the risk is simply too great.

I think it's something I routinely see leaders underestimate, which is, it is not just about them, it is not just about their organisation, it's about the wider world in which everybody has to operate.

In terms of management information, I would absolutely echo what Claire Burns has said, which is, the data is necessary but insufficient, because the data will do something that is unavoidable, which is, it will dehumanise the information. When you're looking at data, you're looking at numbers. It becomes progressively easier to dissociate the numbers from vulnerable children, and we know from many criminal systems that the more you can turn people into numbers, the easier it is, at least, to overlook their humanity and, at worst, absolutely deliberately to dehumanise them.

So I think it's worth thinking about how one both captures the data, but also reminds the people using the data that you're not talking only about numbers here, you're talking about children's lives.

MS HILL: Mr Marsden, anything you'd like to add on these three topics? So it's management and audit information, the voice of the child and the speak-up culture for employees. Anything in particular on those topics you'd like to add?

MR MARSDEN: On the voices of children and families, I think it is worth saying that Myles Bradbury's wrongdoing was only exposed by the actions of a grandparent who rang the hospital the day after an outpatient appointment and raised a flag about an examination that he'd carried out.

I think there was quite a strong sense from the families that we had contact with and spoke to that their understanding about, you know, professional behaviour and what was appropriate and what wasn't appropriate in a clinic setting, and in a clinic setting like the one he worked in, which was treating children with cancer, wasn't entirely clear to them, and I think there is -- firstly, I think they played a real role in stopping his behaviour, but I think there is more to be done about actually explaining the parental and family role in a clinic when they're receiving a service: what can you say, what can you challenge, what can you expect? I think it's something that probably Addenbrooke's have taken on board, but I think that's

something that we could do more about more widely.
In terms of the culture, the speak-up culture, or being open, I've got various points I'd quite like to make, but clearly it remains a challenge, but there have been successes. I think -- little is said about Addenbrooke's. When Bradbury came to light, they dealt very quickly with what had happened, and the concerns were reported by an administrator to someone in the team, I think to a nurse, and then went straight up the organisation and Bradbury left that day, never went back to the Trust.
A colleague of mine says, "We want to develop our people, we need to develop our people to be meerkats, not ostriches", and I think it is a good point. That's what we want people to do. I think Professor Heffernan's point about, you know, people are cynical about that and unsure, I think there has been a history in the NHS of bad treatment of whistleblowers and people feeling marginalised and losing their careers, and Robert Francis has commented about that, but I think it is a real obstacle, and one that we, as managers and leaders, need to do much to overcome.
I said this earlier on, but I will just repeat it for the sake of the record. I think we do need to equip people to understand how predators behave. I think

that's something we haven't done enough about, and I don't think we have done enough to really try and understand, you know, how they behave. But I think it is something that we should do.
I think we need to really anticipate the risks that we take by giving people, particularly senior clinicians, in organisations a special status, and the consequence of, you know, not challenging their behaviour.
I think we need to recognise that organisations often don't respond to weak signals that things are going wrong, and need to be better at that. I think we need to recognise the risks that come from allowing people to operate in isolation. Again, I think that comes back to the -- you know, explaining or sharing with people more widely how predators behave.
I think we need to be clear about how service users, relatives and staff are clear about the protection and the safeguarding that they should expect. I think we need to make it safe for people, you know, safer for people, to raise concerns about the behaviour of their colleagues.
I think we have talked quite a lot about Bradbury, but it would apply to Paterson and Britten as well. People did know, I'm sure, that things were not quite

right. They ascribed a positive -- a sort of a benign motivation to it, but they could have done more, I think, to probably have challenged all of those individuals' behaviour sooner.
MS HILL: Thank you, Mr Marsden. That segues to, Professor Heffernan, your evidence I was going to ask you about, about the whistleblower topic. You have given some evidence in your witness statement at paragraph 17 about the different whistleblower narratives. You have talked about, in the first, the person who sees something wrong, feels compelled to speak up and, as a consequence, is punished and destroyed. You say that that's the stuff of movies and drama.
The second, the truth teller speaks up, the issue is addressed and the organisation is improved. You say that story is almost never told because the organisations themselves rarely like to admit to a problem, especially once it has been solved. But telling that second good news story, if you like, is crucial.
Is there anything else on the issue of responding to the evidence of whistleblowers or external reports, and so on, that you'd like to add, Professor?
PROF HEFFERNAN: The first thing I would say, kind of

following on from Mr Marsden's evidence, is that I think it's important to understand how intimidating formal institutions and people of authority are, especially in very steep hierarchies. The steeper the hierarchy, the more intimidating they are to those in them, because the people above them have power over them. But also to outsiders, you know, like parents or grandparents. You know, typically, however much those institutions try to be user friendly, they are sources of power and they make people feel afraid.
Probably all of us here today are used to dealing with institutions and authority, and we may forget that people who don't deal with sources of power every day are deeply intimidated by them. People are intimidated by their GPs when they go, you know, and want to spend 30 seconds more than the allotted time. So this is -- you know, the power of hierarchies to intimidate I think can't be underestimated.
I think, as far as whistleblowers are concerned, Mr Marsden is absolutely right: the NHS has a really -- I don't use this word lightly -- diabolical history of its treatment of whistleblowers. I have talked to at least 100, probably more, whistleblowers in my time. I have never seen people psychologically so damaged. On one level, they don't regret what they have done,

because they knew it was the right thing to do. But, in many, many instances, their lives have been destroyed by this.

I mean, I spend a lot of my time talking to people within the NHS and persuading them that when people raise concerns, they do this at considerable risk to themselves, and the knee-jerk response is, "Well, they must have an axe to grind" or, "They're a troublemaker, how can we get rid of them?", which I would say is not at all exclusive to the NHS, but this response is both unhelpful and unrealistic. It is a very, very risky thing to speak up and say, "I think there's a problem with a colleague". It feels risky and it feels unfriendly. Nobody does it, by and large, if they don't have a really compelling reason to do it, and nobody does it without thinking long and hard about it.

I think the balance of evidence is that, when people take the risky step of speaking up, the very, very least they're entitled to is a really safe hearing.

The issue about stories being told I think is really fundamental. I mean, I mentor a number of very senior executives of very big, publicly-traded firms, and I am truly astonished at the degree to which even people very high up in these organisations, who have a lot of power and a lot of experience, even they will hesitate to

speak ill of a colleague, even when their misdemeanour may be widely known. So they have power and they don't know how to use it. I would say of that two things.

One, if that is true for people who have power, just imagine how much worse it is for people who feel that they have none.

The second thing I would say is that, it is crucial, when these people do speak up, to be able to report that the problem got fixed. I have certainly myself worked with individuals who finally, with quite a lot of prompting and rehearsal, dared to call out a problem. When it was fixed, (a) there was a huge sense of relief within the organisation -- "My goodness, you actually can get stuff done here" -- but there was a profound reluctance to talk about the lessons learned, like, why has it taken a certain number of years before this happened?

Now, the one instance -- and I know there are more, but this is the only one I have direct personal experience of -- which is of a nurse within the NHS who moved from Mid Staffordshire to North Staffordshire named Helene Donnelly, a position was created where she worked very closely with the chief executive as the person to whom you come when you have intractable problems that seem never to get solved. What she said

to me was, you know, "Yes, when people brought the problems, we could address them, but the even more important thing was to write it up, to circulate it, to talk about it, to make it clear that, actually, when you dare to raise the issue, that is only way it's going to get fixed, and you can never do that too much".

First of all, it gives people hope and confidence in their organisation; secondly, it shows that problems keep coming, because that's the nature of organisational life; and, thirdly, it shows that the whistleblower doesn't get shot.

MS HILL: Thank you, Professor. Finally, Ms Burns, these last two topics that are dealt with together, really, are about both responding to evidence from whistleblowers and Serious Case Reviews, but also responding to other sorts of pressures, such as pressures from the demands of multiple policy and legislative initiatives and things of that nature. On those two topics, Ms Burns, do you want to provide whatever views you have, firstly, perhaps, taking the whistleblower issue, if you want to deal with that? It also covers implementation of Serious Case Reviews, that I think you have dealt with in your witness statement. Do you want to share with the chair and panel your views on that topic?

MS BURNS: Yes. To take you to the -- just to say, I will be talking about significant case reviews, because that's the Scottish term, but the equivalent is a Serious Case Review in England and Wales. This was one of the other key issues that was brought up in the child protection systems review and then was then an integral part of the Child Protection Improvement Plan, and it was a recognition that -- a recognition that there had been a number of significant case reviews when there had been -- a child had died or there had been significant harm to a child and consistently we were seeing the same issue being raised, so an issue of an implementation gap again, and also that some of the recommendations just weren't helpful either. So we had recommendations that -- some that were incredibly specific and some which were really open, such as, "Need to improve data". So we also realised that, in the improvement plan, there was a need to pay greater attention to who was actually doing the case reviews, so especially somewhere that's quite small, like Scotland, it was somebody else who had worked in a neighbouring local authority who maybe had a child protection background, so, you know, that was -- in essence, that was the criteria, somebody who had worked within child protection, rather than thinking about what were the

propensities, the skills and the experience that we wanted those writers to be.

So, as part of the Child Protection Improvement Plan, we looked at what was called the Welsh model, which is a tiered model, which is much more -- has a focus on learning and, how do we actually pull out the learning within these?

So what we have been thinking about in Scotland, and we have been part of as well, is that -- thinking about the reviews should be more timely, proportionate and contribute to an ongoing culture of learning, so rather than just talking about what parts of the system need to change; that there should be national standards developed setting out the skills and competencies required for those who are doing the reviews; and there should also be the appropriate involvement of children and young people and front-line practice as well in that process.

So we are in that process at the moment. We have been -- one local authority particularly had been trialling that out. There's been some really positive feedback around that, which is that the setting up of a multi-agency review panel with the lead reviewer to start off the process was really helpful. There was learning events for key professionals involved with

the child and the family. And that there was, as probably links with the last point, a strong facilitation in a safe and supportive environment to allow people to be very honest about what they thought their misgivings was and where the failings had been.

Two things, really, to say around that, is that we think it is really positive to have that level of being explicit about what are the skills and abilities that we're looking for in somebody to write it; that we're really thinking about the learning, that the learning is actionable, and we put measures in to ensure that those are done. I think those are the -- it's like other aspects of implementation, what I would say is we note this also has been aligned with other processes that, if there is practice issues or competence issues, those are also -- there is a space for those to be dealt with.

What we are slightly concerned is, in Scotland, what we've decided to do is set out some of the principles that we think this approach should look like and that we will leave some of the autonomy up to local areas to decide how they'll implement that. Some concern that, again, we will go back to having 32 ways of doing things and that it will be -- that will allow local areas to almost kind of pick and choose what aspects of the practice of those principles.

Actually, we think they come as a whole. So I think we have a tendency not to want to ascribe to local areas exactly how they do something, and in some ways that's helpful, we have to contextualise it for the local area and the local systems. So, for example, we have some areas where children's education and children's services are in one, sometimes children's services are in with health. So, yes, we have to contextualise it, but we also need to make sure that there's not a kind of almost get-out of, "We will pick and choose some of the principles or effective ways", rather than saying this really comes as a whole.

MS HILL: Thank you. I think, Ms Burns, you have already talked, in fact, about the pressures placed on practitioners to do with excessive policy and legislative changes. With that, chair, those are all the questions I have for these witnesses. Perhaps there will be some questions from the chair and panel for you. Thank you very much indeed.

THE CHAIR: Thank you, Ms Hill. Yes, we have some questions. I will begin and direct this through Professor Heffernan, but I'm happy to hear from the other witnesses.

Questions from THE PANEL

THE CHAIR: My question is about whether the nature of

potential harm to children, or indeed adults, does it make any difference to those who either choose to turn a blind eye or decide to expose an issue, as opposed to, for example, a loss of profit or reputational risk which may have occurred?

PROF HEFFERNAN: It's a very interesting question, and I think there is a difference, and the reason is -- and the difference, I think, is this, which is that, in the world of business, we talk about loss of profit and revenue, and so on, all the time, and it's -- you know, it's very measurable, you can see what it is, you know what it is, it is a sort of objective thing.

I think in studying all the many cases of wilful blindness that I have studied, I think what is unique about the sexual abuse of children is, it's simply such a terrible thing to think about. Nobody wants to think about it. Of course it's socially repellent, it's individually repellent, and so I think the impulse to think, "Well, I must be wrong because it's so horrible, it couldn't possibly be right", or, "I just don't want to think about it at all because it's too disturbing", and it may be too disturbing, also, because it unlocks uncomfortable memories or sensations, I think there's a real kind of extra pull to look away. It's just too painful; it's too difficult; it's ugly.

THE CHAIR: Thank you, Professor Heffernan. Mr Marsden, Ms Burns, do you wish to comment? Mr Marsden?
MR MARSDEN: I think that people probably did know things about Savile's activities. People probably did know things about, or have concerns about, Myles Bradbury. But they were all -- well, Bradbury was -- his motivations and behaviour -- or his behaviour was treated as benign. You know, it was given a good motivation. People ought perhaps to have been more enquiring. And whether they weren't because it's simply too painful and too difficult to recognise the possibility that somebody might be abusing in your service I suppose is an open question. But, yes, I think it is a very difficult issue and I think in both those cases probably more could have been expected earlier.
PROF HEFFERNAN: I would add one thing, which is, you know, it is very well understood within medicine this thing known informally as the secret curriculum, which is about the degree to which medical students, first of all, self-select as quite conservative. If you ask medical students at the beginning of their career would they do something that wasn't entirely correct because a consultant asked them to, the majority will say yes, and by the time they'd finished their medical training,

more of them will say yes. They will have absorbed a message that, "We are an elite, we stick together and we don't", as someone said about Wisheart, the dangerous surgeon in Bristol, "You don't rat out your mates".
I think one of the real difficulties with the sexual abuse of children by people in the medical profession is, it's not just that, as an individual, this is a terrible thing to think about, but it's inconceivable that it should be one of your colleagues.
MR MARSDEN: Yes.
PROF HEFFERNAN: It is just inconceivable.
THE CHAIR: Thank you. Ms Burns, I'm not sure whether this is within the scope of your evidence. Do you have any comment to make?
MS BURNS: No, I don't have any additional comment.
THE CHAIR: Thank you. Another question concerns something that seems to have emerged in the past few years, which is about the recruitment of people to governance structures, such as boards and committees, and that's the recruitment of people described as disrupters. Do you think this has merit?
PROF HEFFERNAN: It's a very difficult question because it begs the question: disruptive of what and of whom? I would say, having sat on, you know, a number of boards of both commercial and charitable organisations, I have

certainly personally had the experience where asking difficult questions led to an invitation that I might wish not to extend my term, and I know that others have had a similar experience. This was from individuals who -- by some of the best-educated and most highly-regarded, thoughtful individuals in the country, which is, "Just don't rock the boat".
I would like to think that when I have been inclined to rock the boat, it's because I thought the boat was in trouble, not because I find it a thrilling thing to do to ask questions that make other people want me to please leave the room, you know. So I think it's tricky, because I think, if you seek to recruit people who like that kind of opposition, like being disliked, as it were, or who come with a preset ideology about the organisation or the way that it works and regard themselves as isolated crusaders, I think that can be very, very damaging. If they are coming with a preconceived sense of what the organisation is and how they somehow magically know how it needs to be changed, that disruption may not be positive and it may indeed not even be in the interests of the organisation. But I do think that my experience, and I would have to say particularly of charitable boards, is that they generally lack diversity, they generally lack an

appreciation that argument/debate/conflict is how organisations think together, and they will, when being questioned, often, you know, kind of stick together against questions, and that, I think, is a persistently troubling aspect of all kinds of corporate governance I've seen both in the UK and the US.
THE CHAIR: Thank you, Professor Heffernan. Mr Marsden, I particularly wanted to ask you in relation to this whether the presence of someone with the title of disruptive would have made any difference to the case examples you've been talking about this afternoon?
MR MARSDEN: Well, I certainly think that non-executives should challenge. I'm not sure about the wisdom of appointing people to specifically disrupt boards, because I think, in a way, all non-executives should be there to challenge and to ask awkward questions. Certainly when -- I remember going to a board, you know, some years ago and them saying, well, you know, "We didn't really know anything about this before it all blew up", and the answer to that was, "Yes, you did. It had come to a board meeting four years previously", and they sort of look downcast, and you have to say to them -- I remember saying it in terms -- "Your job is to be inquisitive. It is to ask more questions", and I do think it is a critical role for non-executives. I don't

think it should be in a disruptive -- as Professor Heffernan says, not in a sort of crusading, "I've got a particular way I want to change this organisation", but I think non-executive directors are there to ask awkward questions, and I've been in plenty of board meetings where that has happened, and it can feel very painful and a bit uncomfortable, but it's also very helpful.

PROF HEFFERNAN: I would say, if I may, two other things. One is, if you are the anointed disrupter, you will quickly be tuned out.

MR MARSDEN: Yes.

PROF HEFFERNAN: I think, in terms of good corporate governance, if you -- I think there is sometimes a value to appointing someone on a particular issue to be the devil's advocate with a disrupter, but that role needs to rotate if people are to take it seriously, and it is a very good exercise in critical thinking and getting boards accustomed to that kind of challenge.

I think the other thing that's quite important is, you know, conflict isn't always disruptive; it should, and can be, constructive, which is, you know, "In order to do this better, we need to ask the following questions ...".

Equally, I would say that there's a ton of evidence

to say that simply asking a question or taking a slightly different position on something can unlock the degree to which everybody else around the table has concerns. So this is a really vital part of any kind of governance.

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

MS SHARPLING: Yes, thank you, chair. This is a question, I think, for Mr Marsden -- it may be Professor Heffernan -- we will see how we go. We have had a lot of evidence throughout the whole inquiry about apologies and acknowledgement towards victims and survivors, and so often we have also heard evidence that, even where a liability may be admitted by the institution, actually attaining an apology from the institution is extremely difficult, and we have heard, in fact, that many of the apologies have actually been given to this inquiry rather than at the time when liability was admitted. I'd be interested in your observations about this phenomenon?

MR MARSDEN: My experience of this practice in the NHS, where I think there's been a big, you know, push over the years to get people -- organisations to be more candid, more straightforward, and apologies made, is it's still, you know, very patchy. I mean, I think that

people will write letters and people will, you know, offer apologies. Whether those receiving them feel that that is truly, sincerely meant and going to be followed up by action I think is open to question. I've certainly encountered, you know, even in fairly recent times, organisations that resist talking to families about things that have gone wrong at a senior level as well. So I think my experience is that there's quite a lot yet to do on that front, really.

MS SHARPLING: Professor Heffernan?

PROF HEFFERNAN: It is a very interesting question. I think -- I will come at this from two different perspectives. In the United States in the healthcare system there is generally a kind of rule that you deny and defend, and it's hugely run by lawyers, if I may be so bold, and there is a fear of apology lest it prejudices subsequent investigation.

Some very interesting work has been done looking in particular at the University of Michigan healthcare system where they decided to try something different and actually just, when a mistake was made -- because medical accidents are a leading cause of death in the United States -- simply go and explain what happened and apologise and talk about how to put it right. This was widely predicted to bankrupt the system. In fact, it

didn't do so. Several excellent things came out of it, chiefly, that the patients who had been harmed tended to recover faster, and they recovered faster partly because they weren't stuck in court cases for years and were able to start thinking about how they would, themselves, recover from the injury, but also they felt respected.

I think that, while an apology -- this is my second point, really -- can't undo damage, what it does do, crucially, I think, is restore people's sense of themselves as human beings, which they feel often gets lost in large organisations. This comes back to my point about data. You know, people very often easily, because they often interact with institutions at moments of vulnerability, they often are made to feel dehumanised. They are talked to by people who don't know them, who -- they may see lots of different people whose names they can't remember, they may not even be introduced, there is often no kind of chronology, as it were, to the relationship, and they feel increasingly both harmed and belittled and the belittlement is part of the harm. What the apology does is, it resets a human-to-human relationship and it takes out some degree of the power differential that has happened when an individual confronts an institution.

This power differential is part of the harm.

MS SHARPLING: That's very helpful, Professor. Thank you. I have one question for Ms Burns, if I may. You have talked, Ms Burns, about the data and how important it is. I was wondering, because there is always a debate, isn't there, between the quality of your data or the qualitative data and the quantitative data and how to get that right balance. But how does a leader, who is probably a senior manager as well as being a leader, as it were, get a clearer line of sight on some of those difficult cases of child sexual abuse, which is why we are here, in the workplace?

MS BURNS: I think it's -- so, first of all, we need to be able to -- we need data systems that will allow us to pull both of those things out. So it needs to give us the quantitative and the qualitative data. At the moment, the data systems don't exist that allow us to do that. So, actually, how do we build those data systems? I think one of the real difficulties for us, particularly in social work and in care and protection, is that we don't often want to put the money into something like that. It fees like it's taking money away from families, it's taking money away from what is frontline services. So I think it is something we need to get over, that, actually, investment in things like data is about supporting families, but it can be very

difficult to justify that, it can be very difficult to legitimise that to finance departments. And we need skilled people who can go and talk to families and talk to them about what their experience has been and be able to feed that back up, so we need, for example -- in Scotland we have Child Protection Committees, so how are we -- how are leaders regularly asking for the quantitative data, the qualitative data and asking the curious questions about that as well. And does this give them assurances that the system is working as intended or not, and how can they then feed that back down. So I think it really is about -- in Scotland, we have seen it's where the investment has come out of our local authorities, it's come out of things like research data, you know, youth and community work that -- where people who are engaged with those kind of communities. So I think it's, how do we reset the balance of care and put investments into some of these preventative pieces? I think Professor Heffernan made a really significant point about saying that the pressure that the system is under at the moment, it's a real double bind for people at the moment because they have got so little money and we know it is better to invest it earlier, but, at the same time, you have to respond to the risk that is coming through the door at

that particular time or the events that have been coming through. I think that's an incredibly difficult place for particularly local authorities to be at the moment.

So I think it's also about permissions to be able to invest in that early intervention piece as well.

MS SHARPLING: Thank you. Does anybody else want to comment on that?

PROF HEFFERNAN: I would simply say -- I think it's exactly right, what Claire Burns has said, about the importance of data. I know that Steve Bolsin, who was the whistleblower in the Bristol babies scandal said that, had they kept better data, they would, years earlier, have been able to identify the extremely high mortality rate in the infant -- in the paediatric cardiac department. So I think this is really crucial, just in terms of saying, "You need to look here. Something wrong is going here", and it won't tell you what it is or how it is, but given that you can't pay equal attention to everything, it will give you a steer as to what questions to ask and where to look.

MS SHARPLING: Thank you.

THE CHAIR: Thank you, Ms Sharpling. Mr Frank?

MR FRANK: Yes, please. Ms Heffernan, if I can begin with you. Going back to the very helpful information you gave us about the subjectivity and the thinness of

the ethical veneer, as it were, in some institutions, you, of course -- I appreciate the context, we are dealing with different types of institutions, but we are dealing with institutions specifically dealing with issues relating to crimes against children, and in particular sexual abuse. There is no ethical ambiguity about that. It is a crime. I don't think, in the entire five years of this inquiry, any institution has come to us and said it shouldn't be. So I think we have ethical parity on that.

Dealing with the other side of that same coin, which is the ambiguity that may arise when it comes to the reporting of that and the failure of senior leaders sometimes to deal with it effectively, do you think that if, in the balance, there were the consideration that my failure to deal with this adequately would be a serious penalty for me, either in the form of a professional penalty or indeed a crime, that that might just swing the balance in favour of protecting children in the way that we think they should be protected?

PROF HEFFERNAN: It is a great question. The short answer is, I don't know. You know, I have certainly known situations where, clearly, criminal activity was going on and it was clear that the individuals who did nothing had a responsibility to do nothing.

I think, in terms of child sexual abuse, the issue is much more often a confusion of, is it specifically my job. This is where, you know -- although, of course, you know, car manufacture and the sexual abuse of children are not at all the same, but this is where the problem lies, which is, well, it could also be the case that this is a job for the police or for the social workers or for the GP or for the teachers or for the parents, or for any number of people, and so then there's a kind of governance issue, are you going to say to all of those people, "You are going to be penalised if you don't speak up"? Maybe. It is a very knotty problem.

When I think about how in financial services there is a much more personal penalty now, you know, if you don't report accurately. Do I think that that has led to deeper self-scrutiny on the part of the individuals concerned? I probably don't. Because people just don't think it's them. I think the blindness happens, as it were, earlier. Because, honestly, you know, you have to ask yourself, if I am so aware of this that I'm only going to be prompted to act by a fear of retribution, I've kind of lost my way morally, ethically, already.

So I'm not sure that it -- I'm pretty confident it doesn't solve the problem. Would it reduce the problem?

I don't know. It might just mean people bury it deeper.

MR FRANK: Thank you very much. I'm going to ask you, Mr Marsden, the same question, particularly in mind of what you summarised very helpfully in your expression, which was that the perpetrators are highly motivated and often more motivated to commit their offences than the organisations are to stop them.

I'm just wondering whether, in the context of that observation, you have anything to say about whether or not having a penalty, in the form of professional or criminal penalty, might make the difference to the organisation being more motivated to stop the offences happening?

MR MARSDEN: I think, on balance, I think probably I don't support the idea of penalties. I think it's a sort of -- I'd much rather tackle it from the point of view of, you know, getting boards and organisations to acknowledge the gravity and importance of these issues and tackle them properly.

I mean, on an unrelated matter, I'm sort of on a campaign to try and improve the way we investigate patient safety incidents in healthcare and harm to patients, and I think that's, you know, something that people want to do and want to do well, but we need to help them do it better. So I'm sort of not convinced

that the sanction would necessarily work.

I mean, there are other, you know, sort of sanctions that work, certainly in organisations, I suppose over things like health and safety, you know, whether that would really therefore -- does it motivate people to behave differently? I'm not sure.

I think my sort of gut feeling is, I wouldn't go down that road.

PROF HEFFERNAN: I think one of the advantages of telling the story of the problem that was righted, which tends to at least provide some glory for the person who raised the issue in the first place, I think that's more compelling in terms of compelling good behaviour than sanctions are productive of stopping bad behaviour.

MR FRANK: Thank you. Just for the sake of completeness, can I put the same question to Ms Burns?

MS BURNS: I don't think there's an evidence base that would support that that in itself would provide a motivating factor, and I think, again, what we have got to keep in mind here as well is the fear of getting that accusation wrong, regardless of what we see -- you know, regardless of picking up the context, this is -- it feels like it is the most serious thing that you can say about somebody, and it is how do you manage that fear about, if you get that wrong. So what are the processes that

are around in organisations that would support you to be able do that in an open way that feels like more of a positive response.

MR MARSDEN: Yes.

MR FRANK: Thank you.

THE CHAIR: Thank you, Mr Frank. Finally, Sir Malcolm?

PROF SIR MALCOLM EVANS: Thank you, yes, and in the spirit of discipline, I shall try to limit myself to only two questions, if I may.

The first maybe sort of in a way resonates and pick up off some of the things, if I can address you first, Ms Burns, that you were saying in response to my colleague's question. In your statement, you said at one point that too much was dominated by a narrative -- an approach dominated by risk. I couldn't help but feel that that was perhaps resonating in a little of what was being said in the conversation we have just been having, that what people seem to be doing too much is responding to where they see is a risk at all levels, even in reporting, but also in day-to-day activity.

Do you think -- I can open this out, and will open it out, to others on the panel too -- there is a way of trying to address these issues which isn't -- obviously, risk must be tackled, but is not so focused on risk. What did you mean by that and what would you think might

be the implications of moving away from a risk-based paradigm, you know, perhaps to a "doing what's right" based paradigm?

MS BURNS: I think from our work in Scotland, certainly what leaders and people at the -- front-line social workers are saying to us is, "We become very good at detecting, particularly around issues of neglect, and then the removal of those children where we think that's appropriate. What we are not good at, then, once we have removed a child, is thinking about what is the support that that child and that family then needs to be able to overcome that trauma, and then we just see at record keeping, in adult services, those children grow up, the trauma has never been dealt with and we are then dealing with those issues in mental health and addiction". So, in terms of being dominated by risk, I think that's forced the system to be that responsive.

I think the other reason is because, actually, there are no services earlier on. We have lost a lot of the preventative services that existed. So the system can only respond with the services that it actually has, which means -- what families are saying to us is, "I tell you at an early stage, or someone tells you at an early stage that there are concerns and the response of the system at the moment is to wait", and it is to

wait until there's an escalation of issues and it meets the threshold for statutory social work environment -- for statutory social work intervention, sorry.

So I think the very way that we have got the system constructed at the moment pushes us to wait until there's a level -- wait until a particular threshold and risk before we actually intervene, and it is often too late.

At the moment, what we are trying to help some local authorities to do is, they are saying it is a vicious cycle of risk because they wait til too long and then things have gone too far with the family and we often have to remove the child, and how do we get back to a virtuous cycle of responding to unmet need in the family at an earlier stage; so how do we shift from thinking about detection and response to risk to thinking about unmet needs at an earlier stage and how do we respond to that unmet need?

PROF SIR MALCOLM EVANS: Thank you. Could I ask if Mr Marsden or Professor Heffernan have anything to add to that?

MR MARSDEN: I'm not sure I do, actually.

PROF SIR MALCOLM EVANS: Fine, yes. Professor Heffernan?

PROF HEFFERNAN: The one thing I would say is, the thing I learned in the years that I've spent researching

wilful blindness is that people often, exactly as Claire Burns says, think, "Well, I'll ignore it and see what happens", and that feels, at best, quite benign, and, at least, kind of safe. But it isn't safe because what you are doing is, you're giving time and opportunity for the problem to get worse. So it doesn't feel like a negative act, but actually it is.

PROF SIR MALCOLM EVANS: Thank you. Perhaps if I could stay with you for a moment and then invite others, if they have any final comments on this.

Rightly or wrongly, I was beginning to get a sense from some of the things you were saying that -- this is an investigation on effective leadership of child protection investigation, but do you think there are limits to what we can expect of effective leadership in tackling these problems? Is the question of better leadership becoming something of a bit of a panacea? Obviously, it is very important, but what are your views on that? Are there limits to what we can expect for improved leadership?

PROF HEFFERNAN: I think that's a fantastic question. I think it is a bit like education: everything is the fault of education, and education is the cure for everything. I think leadership is often seen as, you know, when things go wrong, it's the fault of

leadership, and better leadership is the cure for everything.

I think there is quite an interesting body of evidence emerging that leadership is often a lagging indicator of problems. This is, to me, a very interesting and provocative idea; in other words, leaders are often the last to know, and that's in organisations as well as in governments, frankly.

Along with that goes a big body of work that shows that there's more information at the edge of an organisation, as it were, than at the top; that leaders are actually so far removed from, if you like, the coalface that it makes it very difficult for them to fulfil all the many, many, many roles that we have all described today.

So I think that leadership can be misused as a blanket excuse for why things went wrong, and that's why I tend to believe that, on the one hand, yes, of course you need better, stronger, more competent leadership, which is not that easy to find, frankly, but you also, critically, have to address the more systemic issue, which is creating both systems and a culture whereby it's really easy to say, "I'm a bit worried about this", without feeling that your livelihood is on the line.

My own opinion about that is that, if you are going to have an environment where that's an easy thing to do, it's going to be because I have colleagues whom I know and trust -- not the person right at the top of the hierarchy, but people to the left and right of me, where I can ask, "Do you think this is okay? It kind of bothers me", and we can have that frank conversation of trust, and if we all agree that there's a problem, that feels a lot safer, and we can then collectively try to do something about it.

So I don't think this is an issue only of leadership, but I think creating the environment where those long-term relationships can be developed does have quite a lot to do with leadership, and I would also say that it crucially depends on people being able to work side by side with each other for quite a long time and the casualisation of work, also known as "the gig economy", specifically imperils those relationships of trust.

PROF SIR MALCOLM EVANS: Thank you. Could I ask Mr Marsden or Ms Burns if they have anything to add to that?

MR MARSDEN: I would just add, I think, you know, it can be expected and is important that leaders model the right behaviour for an organisation, and, you know, my experience is, what they are concerned about are the

things that the organisation is probably going to be concerned about, and what gets ignored by them often becomes acceptable.

I think the other thing is, you know, leaders should care about the long-term impacts on organisations, rather than simply day-to-day concerns, and, you know, I would -- certainly when I go to organisations where things have gone wrong, you often ask, you know, are the leaders, are the managers, visible within the organisation, and are they actually, you know, finding out what's happening at the front-line, and I think that's where they connect with the organisation -- not that they can be responsible for everything, but they're setting the tone, they're interested, they're trying to resolve problems that impinge upon the work of, you know, healthcare professionals if it's a healthcare organisation. I think that's their role. It can't be everything, but they're setting, you know, the construct, they're providing the sort of framework in which people should be operating.

PROF SIR MALCOLM EVANS: Thank you. Finally, Ms Burns?

MS BURNS: I think I would just add, to reiterate the point that's been made, leadership is absolutely essential, but, again, not sufficient in and of itself. One of the concerns that I have is that one of the ways in

which we try and manage or try and support leadership is through different leadership programmes. I know in Scotland we have got some leaders who are doing a collective leadership programme and some leaders who are doing, you know, leadership and integration. But, actually, there's no coherence and alignment around what the range of leaders in a particular local authority are saying. It is leadership to some end, to a particular approach. I worry about this isolation of people being on different courses, getting different qualifications around leadership, again, which may -- you know, it may add, it may raise awareness, but it's the coordination alignment that I think Professor Heffernan talked about that is the critical task here for leaders.

PROF SIR MALCOLM EVANS: Thank you. Thank you very much.

THE CHAIR: We have no further questions. Thanks to all the panel members for your evidence. Thank you.

(The witnesses withdrew)

MS HILL: Chair, before we finally close proceedings today, can I very briefly just formally adduce some documentation? As you will remember, we have often done this in the hearings. Can I formally adduce, please, by way of exhibits provided by Ms Burns, the exhibits with reference CEL000001, CEL000004, CEL000005, CEL000011, CEL000012 and CEL00014 and from Dr Peters from the

Institute of Business Ethics the exhibits with IBE000002, IBE000003, IBE000007 and IBE000008.

Thank you very much, chair. That concludes the evidence for today.

THE CHAIR: Thank you very much, Ms Hill.

(4.26 pm)

(The hearing was adjourned to Tuesday, 8 December 2020 at 10.00 am)

INDEX