

<p>1 Monday, 7 December 2020 2 (10.30 am) 3 Welcome and opening remarks by THE CHAIR 4 THE CHAIR: Good morning, everyone. I am Alexis Jay, and 5 I'm the chair of the Independent Inquiry into Child 6 Sexual Abuse. With me are the other panel members of 7 the inquiry: Professor Sir Malcolm Evans, Ivor Frank and 8 Drusilla Sharpling. 9 On behalf of the inquiry, I welcome you all to the 10 substantive hearing into the Effective Leadership of 11 Child Protection Investigation. It is the sixth public 12 hearing to be held remotely by this inquiry. As with 13 other recent virtual hearings, the solicitor to the 14 inquiry sought the views of all core participants in 15 this investigation about the possibility of conducting 16 the hearing remotely. Having received no written 17 submissions in response, I ruled, on 2 November, that 18 a remote hearing was both desirable and practicable. 19 I would like to thank the core participants, 20 witnesses and representatives for their co-operation in 21 preparing for and conducting this hearing, and to thank 22 the inquiry staff for their hard work in making the 23 necessary arrangements. 24 The remote hearing will run for five days, finishing 25 on Friday, 11 December. This investigation will examine</p> <p style="text-align: center;">Page 1</p>	<p>1 the effective leadership of the institutions that fall 2 within the inquiry's terms of reference. This 3 investigation builds on the inquiry's findings on 4 leadership in the interim and investigation reports and 5 it focuses on practical experiences of leadership and 6 management and will examine how effective leadership can 7 better protect children from sexual abuse. 8 Before we hear from Mr Brian Altman QC, lead counsel 9 to the inquiry, some points on timing. We will begin 10 hearing days 2 to 5 at 10.00 am. The timings for each 11 day of the hearing are set out in the hearing timetable, 12 which was published on the inquiry's website. We will 13 take a 15-minute break every hour, and a one-hour break 14 for lunch. We intend to sit no later than 4.00 pm each 15 day. 16 By way of an agenda, we rely on the hearing 17 timetable which sets out the order in which witnesses 18 will be called, save for where unforeseen circumstances 19 require a change to be made. 20 A simultaneous hearing transcript will be produced 21 and is available to those taking part in this hearing 22 via a web browser. The transcript will be published at 23 the end of each day on the inquiry website, and any 24 directions arising from the day's hearing will also be 25 published on the website.</p> <p style="text-align: center;">Page 2</p>
<p>1 Participants are asked to mute their microphones and 2 turn off their camera unless they are speaking. If 3 microphones pick up noise, such as typing, they will 4 place the person on screen as if they were speaking. 5 Turning off cameras will keep the screen from becoming 6 distracting by looking too busy for those using the 7 gallery view. 8 I have made a restriction order protecting the 9 identity of complainant core participants and covering 10 the redactions and ciphers applied in this 11 investigation. For technical reasons, it will not be 12 possible to broadcast this hearing with the usual 13 three-minute delay. All witnesses and core participants 14 have been reminded of these restriction orders, and of 15 the need to take great care in giving evidence or 16 addressing the inquiry to avoid any inadvertent breach 17 of these orders. 18 If there is an inadvertent breach of a restriction 19 order, I will make an immediate further order over the 20 evidence incorrectly given. Members of the public and 21 the press will be prohibited from publishing that 22 evidence. 23 Counsel will provide more information about the 24 victim and survivor evidence we will be hearing in his 25 opening. Please now go ahead, Mr Altman.</p> <p style="text-align: center;">Page 3</p>	<p>1 Opening statement by MR ALTMAN 2 MR ALTMAN: Thank you, chair. Chair, as you know, I am lead 3 counsel to the inquiry and to this investigation. I am 4 assisted by Ms Hill QC and by Mr Fullbrook. 5 This is, as you have said, the public hearing in the 6 Effective Leadership of Child Protection Investigation 7 and it is the 15th and final inquiry investigation into 8 child sexual abuse in various forms and contexts. 9 During the course of its work, the inquiry has heard 10 of several institutional and leadership failures, and 11 has made interim recommendations for significant change 12 to organisations' structure, practices and procedures. 13 Indeed, in its interim report published 14 in April 2018, the inquiry found: 15 "It is self-evident that the quality of leadership 16 and practice within institutions is critical to 17 protecting children, and to preventing and responding to 18 child sexual abuse. This has been seen consistently 19 across all parts of the inquiry's work. 20 "It is important to note that the inquiry's 21 consideration of these issues is not restricted to 22 professionals working within the relevant statutory 23 agencies. In accordance with the inquiry's terms of 24 reference, the inquiry's consideration of leadership and 25 practice extends to all those working in state and</p> <p style="text-align: center;">Page 4</p>

<p>1 non-state institutions that have a role to play in 2 preventing and responding to child sexual abuse -- 3 including those in government, law enforcement, 4 education, healthcare, religious institutions, charities 5 and voluntary sector organisations." 6 In light of this, the inquiry has considered it 7 necessary to conduct a final investigation into the 8 leadership of institutions that fall within the 9 inquiry's terms of reference for protecting children 10 from sexual abuse. This is a thematic investigation 11 which will build on its findings on leadership in the 12 interim and investigation reports, and consider further 13 evidence; it won't, however, be focusing on any 14 individual case studies or institutions. 15 You will recall that a preliminary hearing was held 16 on 26 February of this year, 2020. 17 There are six core participants represented in this 18 investigation. In a moment, I am going to introduce 19 those core participants who are in attendance today. 20 Each representative only appears on screen if they 21 speak, so as I introduce everyone, I would ask them, 22 please, to unmute their microphone, turn on their video 23 and introduce themselves to you, chair, and the panel. 24 First of all, Mr Berry appears both for the National 25 Police Chiefs' Council, the NPCC, and the College of</p> <p style="text-align: center;">Page 5</p>	<p>1 Policing. Mr Berry? 2 MR BERRY: Good morning, chair. Good morning, panel. 3 THE CHAIR: Good morning, Mr Berry. 4 MR ALTMAN: Next, Ms Pollock appears for the National Crime 5 Agency, the NCA. We understand that Mr Sheldon QC, who 6 also represents the NCA in this investigation, will be 7 in attendance on Thursday and Friday only. Ms Pollock? 8 MS POLLOCK: Good morning, chair. Good morning, panel. 9 THE CHAIR: Good morning, Ms Pollock. 10 MR ALTMAN: Mr Gullick and Ms De Coverley appear for Ofsted. 11 MR GULLICK: Good morning, chair, members of the panel. As 12 Mr Altman said, I appear with Ms De Coverley for Ofsted. 13 THE CHAIR: Good morning, Mr Gullick. 14 MR ALTMAN: Finally, Ms Ward appears for the Secretary of 15 State for Education. 16 MS WARD: Good morning, chair and panel. 17 THE CHAIR: Good morning, Ms Ward. 18 MR ALTMAN: In addition to those five, the Independent 19 Schools Inspectorate, the ISI, has been recognised as 20 a core participant but doesn't intend to attend the 21 hearing through the Zoom link, but, we understand, will, 22 rather, follow the live link. 23 Now, the themes which this investigation will 24 consider were set out in the investigation's definition 25 of scope, and they were further elucidated in the</p> <p style="text-align: center;">Page 6</p>
<p>1 investigate's 30 June 2020 update note, and they are 2 these. 3 Embedding ethics and values so that they align with 4 policy and practice. What ethics and values are 5 important for ensuring child protection and how can 6 they, or ethics and values in general, be embedded into 7 an organisation? How do leaders promote a positive 8 culture for tackling child abuse? 9 Next, ensuring organisations are safe and effective 10 at being safe. So, what does organisational safety look 11 like? How can this be achieved and what systems need to 12 be put in place to monitor and record safety? What is 13 the role of governance frameworks and how do leaders 14 ensure that these support their strategy for tackling 15 child sexual abuse? How do leaders ensure that they 16 have clear policies and processes in place to deliver 17 these strategies? 18 Next, achieving openness, transparency and good 19 communication. What does an organisation that is open 20 and transparent about child protection look like and how 21 can an organisation manage the tension between the need 22 to protect the identity of victims of child sexual 23 abuse, whilst at the same time ensuring that it is open 24 and transparent about any potential risks that it 25 identifies? To what extent do leaders engage with</p> <p style="text-align: center;">Page 7</p>	<p>1 children when tackling child abuse? 2 Next, ensuring good communication, the escalation of 3 issues and concerns with clear lines of accountability 4 and good leadership in scenarios where there is no 5 direct line management structure. 6 Next, embedding and ensuring a culture of continuous 7 learning. What does such a culture look like and how 8 can it be bedded into an organisation? 9 The next topic, or theme: using management and audit 10 information to understand the institution, its systems 11 and its performance so that systemic warning signs can 12 be identified early. We will examine evidence from 13 a range of different organisations about their 14 management of information and data, including outside 15 the child protection context. 16 The next theme: responding appropriately to internal 17 and external pressures, for example, from politicians, 18 community leaders, parents, funders and other key 19 stakeholders, so that child welfare and protection is 20 prioritised. We will consider what the sources of 21 external and internal pressure within organisations are, 22 and how they can be managed and harnessed most 23 effectively. We will consider how leaders work in 24 partnership with other agencies and bodies to tackle 25 child sexual abuse.</p> <p style="text-align: center;">Page 8</p>

<p>1 Next, responding to the evidence of whistleblowers 2 and recommendations from inspectorates, Serious Case 3 Reviews and similar reports. How can organisations 4 create an environment in which whistleblowers feel free 5 and able to raise concerns internally? How can 6 organisations ensure that the evidence of whistleblowers 7 and recommendations from inspectorates, Serious Case 8 Reviews and similar reports are implemented, and 9 implemented by staff at all levels, not just by senior 10 management? 11 The next theme is learning from past institutional 12 failures, including from adverse events, including 13 embedding a "learning", not a "blaming", culture. So 14 how can past failures be harnessed to produce positive 15 future outcomes? How does leadership contribute to 16 this? 17 The next theme is exercising good judgment with 18 respect to strategic priorities and risks. What are the 19 strategic priorities and risks for organisations 20 involved in child protection? How can leaders and 21 organisations ensure that they exercise good judgment in 22 relation to them? 23 The relevance of leadership style and how leaders 24 act as positive role models is a further theme. How 25 much difference does leadership style make to the</p> <p style="text-align: center;">Page 9</p>	<p>1 culture and practice of organisations? Which styles 2 have positive impacts and which have negative impacts? 3 How influential can leaders be as role models? How can 4 this drive child protection? How do leaders motivate 5 and develop their staff? 6 Lastly, effective leadership, change and 7 improvement. How can leaders most effectively manage 8 and ensure continuous improvement and innovation, and 9 how is this change implemented? 10 What has the inquiry heard so far about leadership? 11 In addition to the interim report to which I have 12 already referred, the inquiry has identified and 13 reported on a number of leadership failures during the 14 course of its 14 investigations. These have contributed 15 to the scoping and development of this investigation. 16 Let me set out some examples now which relate to the 17 individual themes of this investigation. 18 Embedding ethics and values so that they align with 19 policy and practice. Chair, in the course of this 20 inquiry, you have heard evidence of leaders failing to 21 embed the ethics and values relating to child protection 22 into organisations so that they actually change policy 23 and practice. One example was observed in your 24 investigation into allegations of child sexual abuse 25 linked to Westminster. In your report, you said:</p> <p style="text-align: center;">Page 10</p>
<p>1 "We also heard evidence, notably from the 2 Green Party and the Labour Party, to suggest that there 3 are major gaps in the practical knowledge of even senior 4 people about basic safeguarding principles. It is 5 a matter of grave concern that, even after a significant 6 public outcry about allegations of child sexual abuse 7 linked to Westminster, elected politicians and officers 8 of political parties do not understand how to respond to 9 allegations properly, or consider themselves in 10 a position to make judgments about whether abuse is 11 sufficiently serious to warrant referral." 12 As for the theme ensuring organisations are safe and 13 effective at being safe, chair, you have seen that 14 leaders play an important role in ensuring that their 15 organisations are safe. In the inquiry's investigation 16 into children in custodial institutions, you heard from 17 Angus Mulready-Jones, an inspector of prisons, and 18 quoting from the inquiry's investigation report, you 19 said: 20 "The quality of leadership [in custodial 21 institutions] is not good enough to address the many and 22 complex issues at stake." 23 The next theme: achieving openness, transparency and 24 good communication. Chair, in the course of 25 the inquiry's investigations, you have concluded that</p> <p style="text-align: center;">Page 11</p>	<p>1 a failure of an institution to act openly and 2 transparently can have significant consequences. The 3 Anglican Church case studies report included this 4 finding: 5 "There were a number of occasions on which 6 allegations that ought to have been reported immediately 7 to external authorities were retained internally for as 8 long as possible. The church not only declined to share 9 serious allegations with the relevant statutory 10 agencies, but in at least one case no steps were taken 11 to report known sexual abuse to the police by senior 12 clergy. The absence of co-operation hindered the 13 progress of criminal investigations and safeguarding 14 arrangements and enabled abusers to escape justice." 15 The next theme is ensuring good communication, 16 escalation of issues and concerns with clear lines of 17 accountability and good leadership in scenarios where 18 there is no direct line management structure. In the 19 same report, you identified a clear example of where 20 a failure to set out clear lines of accountability led 21 to increased safeguarding risk. In the report, in 22 relation to Diocese of Chichester, you said: 23 "As a result [of clashing personalities], there was 24 no central oversight of the appointment of clergy within 25 the Diocese of Chichester. No policies existed to</p> <p style="text-align: center;">Page 12</p>

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<p>1 ensure the central retention of files. Decisions were 2 not made and leadership, in respect of safeguarding, was 3 not effective because relationships were poor. As the 4 Archbishops' Council itself conceded: 'The lack of 5 definition of roles and responsibilities, and 6 uncertainties about accountability brought about by the 7 area scheme, contributed to a chaotic and unsatisfactory 8 safeguarding environment.' 9 As for embedding and ensuring a culture of 10 continuous learning, in your report into the inquiry's 11 investigation into child sexual abuse at 12 Cambridge House, Knowl View and Rochdale, you observed 13 the importance of leaders demonstrating a commitment to 14 continuous learning and to addressing issues. You said: 15 "Diana Cavanagh, the Director of Education, 16 commissioned reports and produced her own report. While 17 some of this of useful, each of the reports was flawed 18 in some respects, including factual accuracy. There was 19 no urgency on the part of these senior officials to 20 address the problems of sexual abuse at the school, and 21 matters were left to drift." 22 The next theme is using management and audit 23 information to understand the institution, its systems 24 and its performance, so that systemic warning signs can 25 be identified early.</p> <p style="text-align: center;">Page 13</p>	<p>1 In the same report, you emphasised the importance of 2 leaders making their own enquiries into the performance 3 of their institutions in order to identify issues as 4 they arise and avoid misplaced reliance on others. You 5 said: 6 "Although [Paul Rowen, leader of Rochdale 7 Council] ... boasted that the style of his 8 administration was to be a departure from the past, his 9 misplaced reliance on council officers allowed him to 10 sidestep his own responsibility, and blame others when 11 he never made any, or any sufficient, enquiry either 12 about the really serious problems that affected 13 [Knowl View] ... school and its children or the efforts 14 to deal with those problems while he was leader. This 15 demonstrated a lack of judgment and a failure of 16 leadership." 17 Effective use of management and audit information 18 can enable leaders to spot warning signs themselves and 19 ensure that they take responsibility for addressing 20 them. 21 On the same theme, chair, in the Nottinghamshire 22 Councils' investigation hearing you heard evidence from 23 David White, the former director of Social Services at 24 Nottinghamshire County Council from 1989 to 1994 about 25 the lack of any preordained system for reporting</p> <p style="text-align: center;">Page 14</p>
<p>1 concerns about child sexual abuse to the council's 2 Social Services Committee. This is what he had to say. 3 Can we play the clip, please? 4 (Video played) 5 In your report into Nottingham Councils, you said: 6 "The extent of sexual abuse in foster care in the 7 1970s and 1980s was compounded by poor decision making 8 in those cases where disclosure had been made. Some 9 known perpetrators were permitted to remain as foster 10 carers, and then went on to abuse again. Despite the 11 county's assessment of the prevalence of sexual abuse 12 for children in foster care in the early 1990s, 13 David White, the director of Social Services, failed to 14 take any effective action ... This should have prompted 15 an assessment, at a senior level, of the scale of abuse, 16 why it was happening and how the risk of abuse could be 17 addressed. Despite occasional attempts to consider the 18 issues more broadly, the county failed to address the 19 risk of abuse to children in their care ... Despite 20 being regularly informed of disciplinary action taken 21 against staff (but not foster carers) following 22 investigations into sexual abuse of children in 23 residential care during the late 1980s and 1990s, the 24 county councillors responsible for oversight of 25 children's social care did not question the scale of</p> <p style="text-align: center;">Page 15</p>	<p>1 sexual abuse or what action was being taken. This was 2 a serious failure of scrutiny and governance." 3 Turning now to the next theme: responding 4 appropriately to internal and external pressures, for 5 example, from politicians, community leaders, parents, 6 funders and other key stakeholders, so that child 7 welfare and protection is prioritised. The importance 8 of senior leaders acknowledging and responding to 9 internal and external pressures was identified in your 10 report into Nottinghamshire Councils, in which you said: 11 "Nottinghamshire Police's investigation into 12 allegations of non-recent sexual abuse of children in 13 residential care (Operation Daybreak) was not adequately 14 resourced or supported from its formation in 2011 until 15 2015. Given the increasing number of allegations of 16 abuse and the criticisms from internal and external 17 reviews, senior police officers should have done more to 18 support the operation. The police did not treat the 19 allegations with sufficient seriousness." 20 Now, responding to the evidence of whistleblowers 21 and recommendations from inspectorates, Serious Case 22 Reviews and similar reports. The extent to which 23 organisational culture can create barriers for those 24 wishing to report behaviours of concern was identified, 25 chair, in your report into allegations of child sexual</p> <p style="text-align: center;">Page 16</p>

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<p>1 abuse linked to Westminster. Commenting on the response 2 of the police, you said: 3 "A second form of deference we have heard about is 4 a more internal kind within institutions themselves, 5 such as where junior police officers did not challenge 6 senior officers' questionable decisions during 7 investigations of the powerful for fear of harming their 8 own career prospects." 9 In addition, a clear example of a failure to have 10 due regard to external child protection recommendations 11 can be seen in your report on child sexual abuse within 12 the monastic communities at Ampleforth and Downside. 13 You discussed the independent review on child protection 14 in the Catholic Church, known as the Nolan Report. You 15 explained that in Ampleforth, the abbot, Timothy Wright, 16 "held strong views about child sexual abuse allegations 17 which amounted to a repudiation of the Nolan 18 recommendations. Although he initially appeared to 19 engage with the recommendations, in essence, he wanted 20 nothing to do with their implementation. 21 Moving to the next theme: learning from past 22 institutional failures, including from adverse events, 23 including embedding a "learning", not a "blaming" 24 culture. The failure by leaders to grapple 25 constructively with reports of previous failures and to</p> <p style="text-align: center;">Page 17</p>	<p>1 institute a learning rather than a blaming culture was 2 demonstrated by the Anglican Church's response to abuse 3 by Peter Ball and within the Chichester Diocese. In 4 your report, chair, you said: 5 "Several internal reviews failed to expose the 6 nature and scale of the problem of child sexual abuse 7 within the diocese. Instead, they were used by church 8 leaders to act out their personal conflicts and 9 antagonisms. The reviews ultimately came to nothing 10 until the Archbishop of Canterbury intervened by 11 ordering a Visitation." 12 The next theme is: exercising good judgment with 13 respect to strategic priorities and risks. An example 14 of a failure to exercise good judgment with respect to 15 risk can be found in Lord Steel's handling of 16 allegations against the late Liberal Party MP 17 Cyril Smith. In your report into allegations of child 18 sexual abuse linked to Westminster, chair, you said: 19 "Lord Steel told the inquiry that the allegations 20 had arisen before Cyril Smith had become a member of 21 the Liberal Party and he saw 'no reason, or no locus, to 22 go back to something that had happened during his time 23 as councillor ...'. In effect, that it was nothing to 24 do with him. This failure to recognise the risk that 25 Cyril Smith potentially posed to children was an</p> <p style="text-align: center;">Page 18</p>
<p>1 abdication of responsibility by a political leader and 2 an example of a highly-placed politician turning a blind 3 eye to something that was potentially troublesome to his 4 party, with no apparent regard for criminal acts which 5 might have occurred or for any victims, past or future." 6 You also said: 7 "In 1979, Lord Steel (the leader of 8 the Liberal Party) 'assumed' Sir Cyril Smith had 9 committed offences of child sexual abuse. In our view, 10 rather than give primacy to the protection of children, 11 he yielded to considerations of political expediency and 12 failed to launch a formal internal inquiry into Smith's 13 alleged activities." 14 Let me turn now to the next theme: the relevance of 15 leadership style and how leaders act as positive role 16 models. Chair, you will recall in the inquiry's 17 investigation hearing into the Roman Catholic Church: 18 Ealing Abbey and St Benedict's case study, you heard 19 evidence from Abbot Martin Shipperlee, the 20 Abbot of Ealing, about the way he handled child sexual 21 abuse allegations at Ealing during his abbacy. He said 22 of his own failings in this regard: 23 "As has been serially revealed, my administration of 24 safeguarding is of an insufficient standard ... I have 25 made at least one extraordinary -- a very serious</p> <p style="text-align: center;">Page 19</p>	<p>1 mistake which isn't creditable [sic] to me and that my 2 brethren who have offended have done serious wrong. 3 I can only apologise for what I've done wrong ..." 4 The following day, Abbot Shipperlee's resignation 5 was announced by the Abbot President of the English 6 Benedictine Congregation, Abbot President 7 Christopher Jamison, at the outset of his evidence to 8 you and the panel. This is the clip of what he had to 9 say. 10 (Video played) 11 Chair, in your report into child sexual abuse at 12 Ampleforth and Downside, you highlighted the impact of 13 Abbot Timothy Wright's leadership style. You said: 14 "He clung to outdated beliefs about 'paedophilia' 15 and had an immovable attitude of always knowing best. 16 For much of the time under consideration by the inquiry, 17 the overriding concern in both Ampleforth and Downside 18 was to avoid contact with the local authority or the 19 police at all costs, regardless of the seriousness of 20 the alleged abuse or actual knowledge of its 21 occurrence." 22 In your report into child sexual abuse at 23 Cambridge House, Knowl View and Rochdale, you said of 24 Richard Farnell, a former leader of Rochdale Council: 25 "Regarding Mr Farnell's final statements at the</p> <p style="text-align: center;">Page 20</p>

<p>1 hearing, it was shameful that he refused to accept any 2 personal responsibility for the young lives blighted by 3 what happened at the school while he was leader. 4 Instead, he laid all blame for what occurred at the door 5 of the senior officials in education and 6 Social Services ... 7 "While Mr Farnell washed his hands of Knowl View, 8 some of Rochdale Council's beleaguered officers were 9 left to sort out its many problems. We agree with 10 Ms Hoyano that Mr Farnell was, at the very least, 11 wilfully blind to Knowl View School during his time in 12 office ..." 13 I'm going to now ask the evidence handler to play 14 the relevant clip of Mr Farnell's final statement at the 15 hearing. 16 (Video played) 17 It should be noted that, after providing that 18 evidence, Mr Farnell told the inquiry in writing, and 19 this was also set out in your report, chair: 20 "As council leader during the period of 1986 to 21 1992, I unreservedly accept political responsibility for 22 the actions of the council and its staff and in this 23 case its lack of care and failure to act to protect 24 children, which occurred under my leadership." 25 Now, chair, to the final theme: effective</p> <p style="text-align: center;">Page 21</p>	<p>1 leadership, change and improvement. The importance of 2 leadership in driving necessary change was illustrated 3 by the panel's report into the Anglican Church's 4 response to abuse by Peter Ball and within 5 Chichester Diocese. Commenting on the diocese's 6 response to internal reviews of its handling of child 7 sexual abuse allegations, you said: 8 "The Diocese of Chichester's Past Cases Review in 9 2008-2009 did not unearth the full scale of the abuse 10 that was taking place inside its doors. It failed to 11 take into account the actions of all volunteers and 12 retired clerics. Despite the limitations of this 13 review, the issues that it did raise should have been 14 considered and dealt with by the diocese at the time. 15 This would at least have served to reduce the risks to 16 children and young people. The relationship between 17 Bishop John Hind and Bishop Wallace Benn collapsed 18 during this key period. Their personal conflict 19 distracted the Diocese of Chichester from more pressing 20 matters, particularly the need to address the findings 21 of Mr Meekings and Lady Butler-Sloss. Numerous meetings 22 and discussions took place but seemed to focus on 23 internal squabbles between senior clerics, rather than 24 on the welfare of victims of child sexual abuse ... 25 Bishop Benn failed to recognise that his actions</p> <p style="text-align: center;">Page 22</p>
<p>1 contributed to a paralysis in the diocese. He laid the 2 blame for his own failings on others, including junior 3 members of staff." 4 Overall, chair, it is clear from these examples and 5 others which the inquiry has seen that failures of 6 leadership can significantly harm an organisation's 7 ability to protect children from harm. The purpose of 8 this investigation is to explore how those failures can 9 be avoided. 10 Whilst the report findings provide context for the 11 evidence which you will hear this week, there is no more 12 important context, we suggest, than the powerful and 13 compelling evidence which the inquiry has heard directly 14 from victims and survivors of child sexual abuse. It 15 demonstrates the harm that can arise from ineffective 16 leadership. We are now going to hear two examples of 17 this evidence which illustrates the real-world impact of 18 leadership failures. 19 The first is PR-A10, who gave evidence to the 20 inquiry's investigation into child protection in 21 religious organisations and settings. PR-A10 was 22 sexually abused at the age of 12 by a communion steward 23 within the Methodist Church. She now works supporting 24 victims of abuse. In 2018, she made a formal complaint 25 to the Methodist Church and asked it to review the way</p> <p style="text-align: center;">Page 23</p>	<p>1 in which it had handled her case. In the extract we are 2 about to play, she provides her comments on the church's 3 response and the importance of institutions learning 4 from past mistakes. Before we play the extract, 5 I should add that, in order to provide additional 6 protection of her identity, her voice has also been 7 modulated. Here is what she had to tell the inquiry. 8 (Video played) 9 The second example is Julie Macfarlane, who gave 10 evidence in the inquiry's investigation into the 11 Anglican Church. Ms Macfarlane gave evidence that she 12 was sexually abused by a Church of England rector, 13 AN-F12, at the age of 16. She now works as a legal 14 academic specialising in conflict resolution. In the 15 extract we are about to see, she provides her comments 16 on the church's handling of a civil claim which she made 17 against it, and in particular her concern that the 18 church's outward pronouncements didn't match its 19 internal workings and gave the impression of a lack of 20 transparency. 21 (Video played) 22 In order to ensure that this investigation is 23 grounded in these experiences, and to ensure that 24 institutional evidence is tested from a range of 25 perspectives, we have allocated space throughout the</p> <p style="text-align: center;">Page 24</p>

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<p>1 timetable to read or replay relevant evidence from 2 victims and survivors which the inquiry has already 3 heard in other investigations and which relates to the 4 themes we are examining here. 5 Chair, it is a little before 11.30 am. I wonder if 6 that would be a good opportunity for you to take your 7 break? 8 THE CHAIR: Thank you, Mr Altman. We will return at 9 11.45 am. 10 (11.30 am) 11 (A short break) 12 (11.45 am) 13 THE CHAIR: Mr Altman? 14 MR ALTMAN: Let me now come to the evidence and the 15 timetable to come. Over the course of this week, you 16 will hear evidence from a wide range of perspectives and 17 from a range of sectors, some of which have been 18 selected because they have not been the subject of any 19 detailed consideration by this inquiry before. 20 The evidence is going to start today, when you will 21 hear from academics and professionals who will help to 22 set the context for this investigation by addressing 23 some theoretical elements of leadership and identifying 24 broad areas where leaders have gone wrong in the past 25 and opportunities for future improvement.</p> <p style="text-align: center;">Page 25</p>	<p>1 Tomorrow, Day 2, will focus very broadly on the 2 education sector. The day will start with an excerpt of 3 evidence given in the inquiry's Residential Schools 4 Investigation by a victim and survivor of child sexual 5 abuse perpetrated by a teacher at his school, RS-A7. 6 You will then hear evidence from two headteachers, one 7 serving and one retired, about their practical 8 experience of providing leadership within schools. 9 Following that, you will hear evidence from 10 Karen Manners, who is the interim chair of the Child 11 Safeguarding Practice Review Panel, and Barbara Firth, 12 who has an extensive background in social work, about 13 the mechanisms in place for reviewing and learning 14 lessons from serious child protection failures, and also 15 about any leadership themes and trends which these 16 reviews have identified. The day will conclude with 17 evidence from officials from the Department for 18 Education and the Welsh Government about the role of 19 central government in providing and facilitating 20 effective leadership of child protection. 21 Day 3 will focus, again very broadly, on the local 22 government and care sector. As with Day 2, the day will 23 commence with an excerpt of evidence from victims and 24 survivors -- in this case, from two people who were 25 sexually abused whilst in care and who gave evidence to</p> <p style="text-align: center;">Page 26</p>
<p>1 the inquiry's Lambeth investigation -- LA-A138 and 2 LA-A354. You will then hear evidence from 3 Dame Stella Manzie and Lord Michael Bichard, both of 4 whom have experience of local government leadership and 5 leadership in the wider public sector. Following this, 6 you will hear evidence from groups representing social 7 workers and children in care, and then from a local 8 politician and director of a group which provides 9 children's care services. 10 Day 4 is going to commence with evidence from 11 representatives from independent third sector 12 organisations which provide services for young people. 13 We will then hear evidence from the Football Association 14 and the Scouting Association, two large organisers of 15 voluntary activities for young people, about the 16 particular safeguarding and leadership challenges that 17 arise in this context. The second half of the day will 18 focus on leadership in the criminal justice system, with 19 evidence from two senior police officers, one retired 20 senior police officer and a Chief Crown Prosecutor. 21 On the final day, Day 5, we will start with an 22 excerpt of evidence given to the inquiry's investigation 23 into Child Sexual Exploitation by Organised Networks by 24 a victim and survivor of sexual abuse and by the mother 25 whose daughter was abused, CS-A2 and CS-A12. They</p> <p style="text-align: center;">Page 27</p>	<p>1 comment on a series of institutional failures of 2 leadership. You will then hear evidence broadly 3 relating to the health sector, from Sir Robert Francis 4 QC and Sir David Behan CBE, the former chief executive 5 of the CQC. The investigation will close with the 6 account of a victim and survivor of child sexual abuse 7 who gave evidence to the inquiry's investigation into 8 Nottinghamshire Council, NO-A51, and whose evidence will 9 be read to the investigation in particular about the way 10 in which leaders can work with victims and survivors to 11 improve child protection overall. 12 Chair, a few words about logistical issues regarding 13 the evidence. As is usual, the material obtained for 14 this investigation has been redacted and ciphers have 15 been applied, where the inquiry considers it 16 appropriate, in accordance with the inquiry's protocol 17 on the redaction of documents. There are restriction 18 orders in place that protect the identities, names, 19 addresses and images of any complainant core 20 participants and also the identities of any individual 21 whose identity has been redacted and/or ciphered by the 22 inquiry and any information redacted as sensitive and 23 irrelevant. 24 Chair, you have ruled that these hearings will be 25 held virtually by Zoom and live streamed, as you</p> <p style="text-align: center;">Page 28</p>

<p>1 mentioned when opening this investigation. 2 For those anonymous witnesses who have already given 3 evidence in other investigations whose evidence we 4 propose to replay, counsel will be visible on the 5 screen, the witness will not be visible, but their voice 6 will be heard. Due to the nature of the live stream, it 7 is not possible to subject the broadcasting to 8 a three-minute delay, which you have already mentioned. 9 All witnesses will be reminded of the meaning and effect 10 of any restriction order by their legal representatives 11 and the inquiry legal team before giving evidence and of 12 the need to refer to ciphers for those covered by them 13 and who should remain anonymous. 14 We do invite the assistance of all concerned in 15 respecting the processes in place and promptly drawing 16 to our attention any issues that arise in respect of 17 a breach of a restriction order so that the live stream 18 can be terminated and the matter then resolved. 19 Guidance has been given to core participants how to 20 raise a matter with us in this remote hearing. 21 If there is a breach of a restriction order, counsel 22 to the investigation will say words to the effect of, 23 "An issue has arisen as a result of which I invite you, 24 chair, to terminate the live stream and make an 25 immediate further restriction order covering the</p> <p style="text-align: center;">Page 29</p>	<p>1 evidence just given." 2 We will then invite you to take a short break while 3 the issue is explained to the witness. 4 Chair, that concludes what I have to say to you in 5 opening. You are now going to hear an opening statement 6 from Ofsted, the only core participant who wishes to 7 make one. We will then proceed to the evidence, with 8 Mr Fullbrook reading the statement of Dr Ian Peters, and 9 we turn to the live evidence this afternoon. Thank you, 10 chair. 11 THE CHAIR: Thank you, Mr Altman. Would counsel for Ofsted 12 please go ahead? 13 Opening statement by MR GULLICK 14 MR GULLICK: Thank you, chair. Chair, effective leadership 15 is of major importance when preventing and responding to 16 the sexual abuse of children. Ofsted, the Office for 17 Standards in Education, Children's Services and Skills, 18 is grateful for the opportunity to participate in this 19 important final phase of the inquiry as a core 20 participant. 21 The inquiry has received evidence in relation to 22 this investigation from Her Majesty's Chief Inspector, 23 Amanda Spielman, and Ofsted will make more detailed 24 submissions in relation to that and the other evidence 25 before the inquiry in its written closing.</p> <p style="text-align: center;">Page 30</p>
<p>1 In this opening statement, Ofsted will highlight 2 some of the themes and issues which the inquiry may wish 3 to consider in this investigation. 4 Ofsted has specific inspection criteria for 5 leadership in each of the remits it regulates and 6 inspects. The importance of effective leadership is 7 clear from Ofsted's inspection reports and its wider 8 publications. The impact of safeguarding arrangements 9 is tested in all types of setting and service, and 10 effective leadership of safeguarding is key. 11 Ofsted's findings in these areas will always 12 contribute to the overall judgment on those criteria. 13 Ofsted sees many good examples of leadership in the 14 institutions and local authority that it inspects and 15 regulates, including in schools, children's homes and 16 the secure estate. Where Ofsted finds that settings are 17 inadequate, the universal theme is weaknesses and 18 failings in leadership and management. This is most 19 commonly found in terms of ineffective oversight and 20 poor monitoring systems and a lack of direct sight of 21 what is happening for children. 22 Weaknesses in leadership are seen across the range 23 of settings. Where Ofsted has required children's homes 24 to act to improve the safety and protection of children, 25 this is most often to address weak leadership and</p> <p style="text-align: center;">Page 31</p>	<p>1 management. Complaints to Ofsted about schools are 2 predominantly about leadership and management, pupils' 3 well-being or both. Effective leadership is, therefore, 4 especially important not just at the national, regional 5 or local authority level, but within each individual 6 setting where children are looked after or educated. 7 Conversely, where settings are improving, they tend 8 to show characteristics of good leadership, something 9 set out in Ofsted's recent annual report for 2019/2020 10 in relation to what are described as "stuck" schools, 11 that is, schools that have not had a rating of "good" or 12 "outstanding" since 2007. 13 The inquiry has raised several questions about 14 effective leadership in child protection. As a core 15 participant, Ofsted wishes to focus in this opening 16 statement on three areas to which the inquiry may wish 17 to pay particular attention. Firstly, the key qualities 18 of an effective leader. Secondly, how leadership has 19 been impacted by the COVID-19 pandemic. And, thirdly, 20 what needs to change. 21 Turning briefly to the first of those areas, the key 22 qualities of an effective leader. Not all good leaders 23 possess the same qualities, but many leaders do appear 24 to share a common set of talents, values and behaviours. 25 Ofsted has conducted its own research into the qualities</p> <p style="text-align: center;">Page 32</p>

<p>1 of effective leadership to improve its inspection 2 practice. Ofsted's 2015 report into effective 3 leadership of children's services drew on evidence from 4 visits to nine local authorities and identified the 5 following common characteristics of effective leaders in 6 children's services: 7 Openness to possibilities; the ability to 8 collaborate; demonstrating a belief in their team and 9 people; personal resilience and tenacity; the ability to 10 create and sustain commitment across a system; focusing 11 on results and outcomes; the ability to simplify; and 12 the ability to learn continuously. 13 Similar findings were made in the research conducted 14 to develop Ofsted's current education inspection 15 framework in use from September 2019 which is set out in 16 more detail in Ms Spielman's evidence. 17 Ms Spielman has also set out two additional 18 principles in her evidence: honesty and integrity. 19 These are essential characteristics for leaders ensuring 20 effective child protection in any organisation. 21 During the inquiry's previous investigations, Ofsted 22 has given evidence about leaders who do not act honestly 23 or with integrity or who conceal child protection 24 matters. Ms Spielman has also given evidence about the 25 need for ethical working.</p> <p style="text-align: center;">Page 33</p>	<p>1 Leaders set the tone for their organisations, and 2 need to ensure a culture of openness and transparency so 3 that children and staff can speak out. Ofsted is 4 interested in learning, as the inquiry examines the 5 evidence during the course of this investigation, how 6 all these qualities are recognised across the wide range 7 of different sectors giving evidence -- in education, 8 local government, the voluntary and third sector, the 9 criminal justice system and in health. 10 Turning to the second of the areas I referred to 11 earlier, the impact of the COVID-19 pandemic on 12 leadership. Both the education and social care systems 13 have been severely disrupted by the pandemic. The 14 effect on the safeguarding of children cannot be 15 underestimated. Effective leadership in this context 16 and at this time and in the future whilst the pandemic 17 continues and its effects continue to be felt is 18 therefore of particular importance. 19 Given the timing of this investigation, the inquiry 20 is well placed to consider these issues. 21 Ofsted has seen many good examples of effective 22 leadership during this pandemic. It has also seen poor 23 examples of leadership and examples where leaders have 24 struggled under the strain the pandemic has brought on 25 all of us.</p> <p style="text-align: center;">Page 34</p>
<p>1 Ofsted looks forward to hearing a range of examples 2 this week about how child safeguarding issues raised by 3 COVID-19 are being dealt with well by leaders and 4 recommendations from different sectors about how to 5 maintain effective leadership in child protection during 6 this difficult time. 7 The pandemic has highlighted the critical role that 8 schools play in children's lives. Ofsted's findings 9 from its interim visits to schools showed the great 10 effort leaders have made to respond to the challenge of 11 fully re-opening. Many leaders told inspectors that 12 they have progressed safeguarding training during the 13 months when schools were closed during the first 14 national lockdown. This included training on 15 identifying and addressing safeguarding concerns while 16 pupils were being educated remotely. 17 Ofsted has seen falling referrals to children's 18 social care because of school closures. This is of 19 significant concern. This is changing as schools 20 return, but there is concern that some children, 21 particularly those for whom their homes may not be 22 a safe space, are still hidden from view because of the 23 lack of professional involvement in their lives. Many 24 children have not returned to school at all. Many 25 children with special educational needs and</p> <p style="text-align: center;">Page 35</p>	<p>1 disabilities, and their parents, have particularly 2 struggled during lockdown as many services and sources 3 of support, social care, educational and therapeutic 4 have been disrupted or withdrawn. COVID-19 has 5 undoubtedly added another layer of complexity to the 6 child protection sphere and the way in which leaders 7 have addressed their responsibilities in this respect 8 during the pandemic and how they have learned from and 9 adapted to the unprecedented circumstances, including 10 changing patterns of child sexual abuse and 11 exploitation, may be of particular interest to the 12 inquiry. 13 Many of the leaders that inspectors spoke to, 14 particularly in early years, and in local authorities, 15 have felt financial pressures as a result of 16 the pandemic. Ofsted has also found that schools that 17 are graded higher for leadership and management than for 18 overall effectiveness are disproportionately in deprived 19 areas. To what extent do limited budgets, capacity and 20 resources and the social and economic context of 21 settings in which children are looked after affect 22 effective leadership in the field of child protection? 23 This is an issue that Ofsted hopes will be addressed 24 during the investigation. 25 Compounding this, leaders across all sectors have</p> <p style="text-align: center;">Page 36</p>

<p>1 told inspectors they and their teams have felt added 2 stress and uncertainty this year. All sectors are 3 showing signs of fatigue. This is something Ofsted is 4 greatly concerned about and is something it hopes the 5 investigation will consider when looking at the issue of 6 effective leadership. 7 Turning, finally, to the third area of what needs to 8 change, Ofsted has made a range of recommendations to 9 this inquiry across its several investigations. Many of 10 those recommendations relate to improving requirements 11 on leaders of institutions in order to improve child 12 protection. How such improvements might be taken 13 forward, itself requiring effective leadership in the 14 management of change, may also be an issue that the 15 inquiry wishes to consider during this investigation. 16 I will briefly turn to some areas on which Ofsted has 17 already made submissions in other investigations. 18 The police, health and local authorities are 19 together responsible for local safeguarding 20 arrangements. Ofsted has consistently said that no one 21 agency can tackle abuse on its own. It is when agencies 22 work together effectively that there are better outcomes 23 for children. Ensuring effective partnership working is 24 a key responsibility of leaders in these fields. The 25 inquiry had the opportunity to look at partnership</p> <p style="text-align: center;">Page 37</p>	<p>1 working arrangements in its recent investigation into 2 child sexual exploitation by organised networks. 3 Effective multi-agency working was one of the issues 4 raised by Ofsted in its submissions to the inquiry in 5 that investigation, and leaders at all levels have an 6 important role to play in that respect. This 7 investigation may want to consider whether we can be 8 confident all leaders are appropriately held to account 9 in relation to multi-agency safeguarding arrangements. 10 This is particularly the case in the health sector, with 11 its complex and diverse range of organisations and 12 accountability arrangements. 13 Ofsted has also made recommendations which relate to 14 improving information sharing and effective partnership 15 relationships. This includes improving links between 16 schools and local authority designated officers, between 17 different local authority departments, across local 18 partnerships and between national level bodies, such as 19 the Teaching Regulation Authority, the Independent 20 Schools Inspectorate and Ofsted itself. 21 During the Residential Schools Investigation, Ofsted 22 also proposed strengthening the standard for leadership 23 and management contained in the Independent School 24 Standards to ensure that all schools have governance 25 structures that result in headteachers being held to</p> <p style="text-align: center;">Page 38</p>
<p>1 account effectively. 2 Given the crucial role that governors play in 3 overseeing safeguarding, Ofsted is also in favour of new 4 standards which introduce mandatory safeguarding 5 training for governors of independent schools. This 6 would support them to carry out their roles which are 7 often voluntary, effectively, and to be critical friends 8 of the schools' senior leaders. 9 Ofsted has also recommended improvements to various 10 aspects of statutory guidance, such as Working Together 11 to Safeguard Children, and Keeping Children Safe in 12 Education, so that leaders can use these to create and 13 sustain an effective safeguarding system within their 14 setting. 15 Chair, Ofsted looks forward to hearing the evidence 16 of the witnesses in this investigation and what they 17 each recommend to the inquiry to improve the effective 18 leadership of child protection. Chair, that concludes 19 the opening statement on behalf of Ofsted. 20 THE CHAIR: Thank you very much. We now turn to 21 Mr Fullbrook. 22 Summary of statement of DR IAN PETERS MBE (read) 23 MR FULLBROOK: Thank you, chair. I am now going to read the 24 witness statement which was provided to the inquiry by 25 Dr Ian Peters MBE, the director of the Institute for</p> <p style="text-align: center;">Page 39</p>	<p>1 Business Ethics. The statement is at URN IBE000013. 2 He says as follows: 3 "The Institute for Business Ethics (IBE) has been 4 invited by the independent inquiry into child sexual 5 abuse to submit a witness statement which addresses the 6 principles underlying good ethics policy and practice in 7 organisations including the importance of providing 8 effective speak-up arrangements. 9 "This witness statement is submitted on behalf of 10 the IBE by Dr Ian Peters MBE, director. As director of 11 the institute, Ian is responsible for implementing 12 strategy, leading the team and ensuring that the 13 institute meets its charitable aims of raising awareness 14 and spreading best practice in the field of business 15 ethics. 16 "The IBE is an independent educational charity which 17 exists to promote high standards of business behaviour 18 based on ethical values. We were established in 1986 19 and, for over 30 years, we have advised organisations 20 and organisational leadership on how to strengthen their 21 ethical culture by sharing knowledge and good practice. 22 We believe that doing business ethically makes for 23 better businesses and better results in relationships 24 and reputations with employees and other stakeholders 25 that are based on trust.</p> <p style="text-align: center;">Page 40</p>

<p>1 "We have developed a business ethics framework to 2 reflect a mature ethics programme which is based on the 3 experience of leading corporate practice from our 4 network of supporter organisations. The framework 5 begins with ethical values which are embedded into 6 organisational culture through an ethics programme, the 7 foundation of which is a code of ethics. This then also 8 needs to be supported by communication and engagement 9 activities, training and reinforcement, leadership, 10 supportive environment and speak-up and risk assessment, 11 monitoring and accountability. This framework forms the 12 structure of our response. A visualisation of this 13 framework is included as a separate attachment." 14 That's exhibit IB1 of his statement: 15 "Ethical values. 16 "For an organisation to demonstrate that it is 17 serious about its commitment to business ethics, the 18 ethical values of the organisation should be reflected 19 along with the business values in the purpose statement 20 of the organisation, in the strategy, governance and 21 ethics policy, as well as in the decision-making process 22 in the organisation. 23 "It is important to note that not all values 24 espoused by organisations are ethical values. Core 25 value statements of organisations often include</p> <p style="text-align: center;">Page 41</p>	<p>1 a mixture of ethical value words, such as 'fairness', 2 'respect', 'integrity', 'care', et cetera, as well as 3 business or operational value words such as 4 'innovation', 'customer service', 'profitability', 5 'safety', et cetera. Both are necessary for 6 organisations to thrive commercially, but the balance 7 between the two must be maintained as they potentially 8 drive different outcomes when used as a basis for 9 organisational decision making, whether in the purpose 10 statement, business model, strategy and governance of 11 the leadership of the organisation or in the day-to-day 12 decision making of employees at any level. 13 "We define business ethics as 'the application of 14 ethical values to business behaviour' and are therefore 15 interested in 'how' business is conducted, that is, is 16 it conducted with respect to stated ethical values 17 rather than 'what' an organisation does, that is, its 18 business model, or why it does it, that is, its purpose? 19 "To promote ethical decision making in 20 organisations, we advocate the use of decision-making 21 models, whether for the big ticket items in the 22 boardroom or in operational decision making on 23 a day-to-day basis. Posing a series of simple 24 questions, such as, 'Would I be happy to see this 25 decision on the front of the newspaper?', 'What would</p> <p style="text-align: center;">Page 42</p>
<p>1 happen if everyone in the organisation did this?' or 2 'Who will this decision affect or hurt?', are effective 3 ways of promoting informed, ethical decision making. 4 Collating short question sets, including those listed 5 above, into a decision-making model or decision tree 6 which can be propagated through the activities of an 7 ethics programme is considered to be best practice. 8 More information about the decision-making models, 9 including examples, can be found in our good practice 10 guide publication, 'Ethics in decision making', which is 11 included as a separate attachment to the statement. 12 "Responsibility for corporate ethics should sit with 13 the governance of the organisation and our board 14 briefing publication, 'Ethics Risk and Governance', sets 15 out why directors need to be actively involved in 16 setting and maintaining a company's ethical values and 17 suggest some ways to approach it by helping directors 18 define their contribution to the maintenance of sound 19 values and culture. A copy of this publication is 20 included as a separate attachment to the statement. 21 "Codes of ethics. 22 "Codes of ethics, or, alternatively referred to as 23 codes of conduct, are the foundation of an 24 organisation's ethics programme. They can be compared 25 to a map offering guidance to staff of what route to</p> <p style="text-align: center;">Page 43</p>	<p>1 take when there is a choice to make. 2 "For over 30 years, we have researched the use of 3 corporate codes of ethics and our research shows us that 4 in the last few years there has been a shift in the 5 primary purpose of such documents. Historically, the 6 number one reason given as to why companies have a code 7 of ethics has been to provide guidance to staff. 8 However, when we last conducted this research in 2019, 9 for the first time the leading response was, to create 10 a shared and consistent company culture, suggesting 11 a change in the approach of leading organisations with 12 regard to the focus of their ethics programmes. This 13 research is detailed further in our survey report, 14 'Embedding Business Ethics: 2020 report on corporate 15 ethics policy and programmes', a copy of which is 16 included as a separate attachment to the statement. 17 "An effective code of ethics should set out the 18 expectations that the organisation has for how employees 19 should behave in any given situation. The best also set 20 out what employees and other stakeholders can expect 21 from the organisation in return. 22 "It is also important to note that every code should 23 be tailored to the organisation and that one size never 24 fits all. Our full guidance on codes of ethics is 25 available in our publication, 'Codes of Business Ethics:</p> <p style="text-align: center;">Page 44</p>

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<p>1 a guide to developing and implementing an effective 2 code', which is included in a separate attachment to the 3 statement. 4 "Codes of ethics should be engaging, user-friendly 5 documents which are written in accessible language and 6 include effective design elements, such as comprehension 7 aids, FAQs, scenarios and dilemmas, to help translate 8 ideas, concepts and standards into day-to-day 9 application. Translation of the text into local 10 languages is also recommended where organisations 11 operate internationally. Additional ways in which codes 12 of ethics can be made accessible is through the 13 utilisation of technology where appropriate. Many 14 organisations now feel that they do not need a printed 15 version of the code and that an online version, whether 16 in PDF, web or even app format, will suffice. Utilising 17 technology can be effective, but must be based on the 18 needs of the workforce. For example, some companies 19 require printed versions of their code to ensure that 20 the content is accessible for offline populations, such 21 as remote or non-office-based workers who may not be 22 provided with a company device or computer time as part 23 of their role. 24 "Good practice is also to write the code for the 25 benefit of employees but to make it publicly available.</p> <p style="text-align: center;">Page 45</p>	<p>1 On the last count, 78 of the FTSE 100 do make their 2 codes publicly available through their websites. 3 "It is important to remember, however, that a code 4 of ethics is necessary but not sufficient on its own and 5 needs to be supported by the additional elements of an 6 ethics programme, as explained below. 7 "Communication and engagement. 8 "An organisation's ethical standards must be 9 communicated to employees and relevant stakeholders on 10 a regular basis. Building a drumbeat of communications 11 on ethical issues is critical to promoting employee 12 engagement with ethical issues and creating an 13 environment where employees feel both empowered to do 14 the right thing, ie, make ethical decisions, and 15 supported in doing so. 16 "Communicating ethical values is not as simple as 17 informing employees about facts, figures and procedures 18 and checking they are compliant. Discussions about 19 ethics must start with concepts that touch employees' 20 own experience. Story-telling is an effective way of 21 achieving this. In many organisations there still 22 exists the language of compliance, punishment and of 23 mistrust. This characterises employees as without 24 ethics and needing to be reeducated into the company way 25 or face punishment. This approach decreases trust and</p> <p style="text-align: center;">Page 46</p>
<p>1 perpetuates the myth that ethical standards are caused 2 by a few bad apples without looking at the wider company 3 culture. 4 "Giving employees the tools to enhance their ethical 5 acumen and 'do the right thing', trusting them to make 6 choices in line with ethical values and respecting them 7 when they speak up are values-led ways to produce a 8 'Pygmalion effect'. If people are seen and treated 9 positively, this influences the way they act in 10 a beneficial way. 11 "Our full guidance on communications and ethics can 12 be found in our good practice guide publication 13 'Communicating Ethical Values Internally', which is 14 attached to the statement. 15 "Training and reinforcement. 16 "A third activity of an ethics programme which seeks 17 to embed ethics into an organisation and align policies 18 and practices is training. Effective training will 19 provide positive reinforcement of the key messages and 20 commitments espoused and, when done well, for many, it 21 is the best opportunity to see most clearly how 22 potentially philosophical concepts actually apply to 23 their roles. 24 "Training should not be limited to a compliance 25 tick-the-box approach, focused more on ensuring a set</p> <p style="text-align: center;">Page 47</p>	<p>1 target of completion/participation rates than on 2 transferring the relevant knowledge and skills required 3 to live up to the organisation's ethical commitments. 4 Such measurement of whether training has been understood 5 and applied is more of a challenge but is possible. 6 "An effective ethics training strategy should 7 articulate the desired outcomes it is designed to 8 achieve and the indicators that can be used to measure 9 success. More information is provided under the 'Risk 10 Assessment, Monitoring and Accountability' heading 11 below. 12 "It is important not to limit training or ethics 13 education to a once-a-year learning experience, whether 14 a classroom-based or e-learning session, and to 15 recognise that people learn outside of this environment, 16 informally, through those around them and through their 17 on-the-job experiences. 18 "The use of scenarios or ethical dilemmas in 19 training is considered to be the most effective use of 20 training time, as they create the experiences which 21 people can learn from without actually creating 22 unethical situations in which to test employees. They 23 help to sensitise staff to the ethical dilemmas they may 24 face in their day-to-day work by giving them the 25 confidence to deal with those dilemmas in a manner</p> <p style="text-align: center;">Page 48</p>

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<p>1 consistent with the organisation's ethical values. 2 "Leadership, supportive environment and speak-up. 3 "Fourth, there are a number of contextual elements 4 which impact the ability for ethics to become embedded 5 throughout an organisation and the ability and 6 willingness for employees to adopt the espoused 7 standards of their organisation in their day-to-day 8 work. These include the example of leadership, how 9 supportive the environment they are operating in is and 10 the extent to which they are free to speak up in their 11 place of work. 12 "Leadership is a key driver of ethical performance 13 in an organisation and much is written about the impact 14 of the tone at the top of an organisation. Leadership 15 is as essential to business ethics as ethical qualities 16 are essential to good leadership. It is the leader of 17 a business that sets the tone of the behaviour of 18 the company. In the immediacy of the organisation 19 a leader is seeking to run, he or she needs to be aware 20 of the example they are personally setting for their 21 employees. On a tribal level, followers try to emulate 22 their leaders as a means of advancement. This is 23 explained further in our publication 'Setting the Tone: 24 Ethical Business Leadership' which is attached 25 separately to the statement.</p> <p style="text-align: center;">Page 49</p>	<p>1 "It is also important to recognise that there are 2 'leaders' at every level in an organisation and the tone 3 set locally will have a significant impact on the extent 4 to which a local environment may or may not be 5 supportive for ethics. Therefore, 'tone from above' may 6 be a more relevant concept. Research into embedding 7 ethics in the workplace indicates that employees 8 consider their line manager as the biggest enabler and 9 teacher of ethics in their organisation. The statement 10 quotes or cites Stevens, B (1999) 'Communicating Ethical 11 Values: A Study of Employee Perceptions', in the Journal 12 of Business Ethics, volume 20, number 2, pages 113 to 13 120. 14 "Another measure of how supportive the local 15 environment is for ethics is whether or not ethical 16 matters are incorporated into the performance management 17 processes of the organisation. Particularly critical is 18 that the employees are assessed and rewarded based on 19 how they achieve their goals, as well as what they 20 achieve. This is important to emphasise that the ends 21 do not justify the means. This is explained further in 22 our good practice guide publication 'Performance 23 management for an ethical culture' which is attached to 24 the statement. 25 "Next, the freedom to raise concerns without fear of</p> <p style="text-align: center;">Page 50</p>
<p>1 retaliation is a core component of a supportive, ethical 2 business culture, one where employees are confident they 3 will be supported to do the right thing. From our 4 latest research, 24 per cent of UK employees tell us 5 that they have been aware of some form of misconduct at 6 work in the previous 12 months. However, only 7 67 per cent said that they raised their concerns, ie, 8 that they spoke up about the issue. The top reasons 9 those who did not speak up gave were: that they did not 10 want to jeopardise their job; that they thought no 11 corrective action would be taken; and that they did not 12 want to potentially alienate themselves from colleagues. 13 The full results of the survey are available in our 14 publication 'Ethics at Work: 2018 Survey of Employees - 15 United Kingdom' and a copy is attached to the statement. 16 "To embed a speak-up culture in an organisation, 17 employees must be supported in the ability to speak up 18 when they become aware of misconduct. This can be 19 achieved both through the provision of comprehensive 20 speak-up arrangements and reporting channels, but also 21 through managers creating psychologically safe 22 environments where ideas can be raised and 23 constructively challenged and concerns called out. 24 However, more than just encouraging employees to voice 25 their concerns, they also need to be heard and the</p> <p style="text-align: center;">Page 51</p>	<p>1 organisation needs to be able to listen up effectively. 2 Finally, once a concern has been raised and heard, it 3 also needs to be followed up appropriately. This will 4 require having appropriate escalation policies and 5 procedures and a thorough, well-equipped and 6 well-resourced investigations process to be able to 7 determine the root causes of the issue and then take 8 appropriate action and develop additional controls to 9 prevent reoccurrence. 10 "Our good practice guide publication 'Encouraging 11 a speak-up culture' looks at practical ways that 12 organisations can encourage a speak-up culture and 13 includes guidance on establishing and embedding 14 a procedure that gives employees confidence to raise 15 concerns about anything they find unsafe, unethical or 16 unlawful. A copy of that publication is attached to the 17 statement. 18 "Risk assessment, monitoring and accountability. 19 "Lastly, risk assessment, monitoring and 20 accountability are also core components of a mature 21 ethics programme. However, good practices on these 22 three areas are not as well developed as they are in 23 other parts of the framework. 24 "The conducting of risk assessments allows for the 25 prioritisation of resources on the biggest risks facing</p> <p style="text-align: center;">Page 52</p>

<p>1 an organisation from an ethical perspective. For many, 2 ethical lapses and scandals play out as a loss of trust 3 and damaged reputation which result from poor 4 behaviours. For an ethics programme to be effective, 5 the severity and likelihood of the risks needs to be 6 understood so that they can be effectively managed 7 through appropriate controls. 8 "Second, the ethical culture of an organisation 9 should be proactively monitored to ensure that any 10 pockets of weak culture are identified and addressed. 11 As noted above, many directors agree that culture cannot 12 easily be measured. However, there are many proxy 13 indicators of culture in existing management 14 information, and boards can, and do, have access to 15 a range of information which sheds light on the drivers 16 of behaviour within their organisation and will help 17 them to shape it in the desired way. 18 "Most regularly, boards look at speak-up and 19 whistleblowing data, the results of employee surveys and 20 health and safety data, as well as items in the public 21 eye, such as taxation policy and diversity. Less 22 attention is paid to issues such as customer complaints, 23 supply chain data, social media records and exit 24 interviews, all of which might provide important 25 insight. Directors also need both quantitative and</p> <p style="text-align: center;">Page 53</p>	<p>1 qualitative data, but where KPIs are concerned, they 2 need to look beyond the raw figures to understand the 3 underlying message and compare results with other 4 indicators to see whether they confirm the picture. 5 More on the information received by boards, how they 6 consider it and how they report on culture to the 7 outside world, can be found in our board briefing 8 publication, 'Culture Indicators: understanding 9 corporate behaviour', a copy of which is attached 10 separately to the statement. However, further research 11 in our survey report 'Embedding Business Ethics: 2020 12 report on corporate ethics, policies and programmes', 13 which has been mentioned previously, reveals that fewer 14 than half of large organisations in our survey sample 15 say that their board receives mandatory ethics 16 training -- only 46 per cent; almost a quarter say that 17 ethics doesn't play a part in the board's performance 18 appraisal -- 24 per cent; and a fifth say that matters 19 of ethics are not regularly discussed in board 20 meetings -- 20 per cent. 21 "Finally, it is also important that there is 22 accountability for the commitment to ethics. Internally 23 and with staff, this can be ensured through the 24 integration of ethics criteria into performance 25 management processes, as described above. Externally,</p> <p style="text-align: center;">Page 54</p>
<p>1 how an organisation reports on its commitment to ethics 2 and actions taken must be authentic. Companies will not 3 be believed if their communication is spun in a way that 4 simply presents a positive gloss. The introduction of 5 section 172 of the Companies Act 2006 provides boards 6 with a clearer framework for decision making. However, 7 a string of corporate failures led the government to 8 require boards of large companies to report on how they 9 have discharged their duties under section 172. In this 10 regard, companies should be required to go beyond their 11 legal requirements. Our board briefing publication, 12 'Ethics and Section 172: key questions for informed 13 board decision making' provides practical guidance for 14 boards around making decisions as a group, answers key 15 questions and highlights issues for individual directors 16 to consider. A copy is attached separately. 17 "In summary, to be effective in embedding ethics 18 into an organisation and align policies and practices, 19 all of the elements described above need to be 20 co-ordinated and sufficiently resourced. If not, the 21 danger is that a gap will develop between what an 22 organisation says it is committed to and what it does in 23 practice, ie, the say/do gap. The wider the gap, the 24 greater the potential for ethical lapses and scandals." 25 Chair, that concludes the statement of Dr Ian Peters</p> <p style="text-align: center;">Page 55</p>	<p>1 and I think that concludes the evidence that we have 2 this morning. I'm informed that the witnesses for this 3 afternoon won't be available until 2.00 pm, so with your 4 leave, chair, I suggest we take a slightly longer lunch 5 break and return at 2.00 pm. 6 THE CHAIR: Thank you, Mr Fullbrook, we will do that. 7 (12.30 pm) 8 (The short adjournment) 9 (2.00 pm) 10 THE CHAIR: Good afternoon, everyone. Ms Hill? 11 MS HILL: Thank you, chair. Chair, this afternoon we have 12 three witnesses giving evidence concurrently to provide 13 you and the panel with some context for the evidence 14 that will come later this week. 15 MS CLAIRE BURNS (affirmed) 16 PROFESSOR MARGARET HEFFERNAN (affirmed) 17 MR ED MARSDEN (affirmed) 18 Examination by MS HILL 19 MS HILL: I will address my comments to all three witnesses, 20 to start with, please. I hope you can see and hear me 21 all right, but if, at any point, you can't see or hear, 22 then please do indicate. As you know, I will be asking 23 you some questions by following the order set out on the 24 topics list that I hope you have all been sent. 25 We will go from now until 3.00 pm, by which point we</p> <p style="text-align: center;">Page 56</p>

<p>1 will have a break. But if, at any point, you need 2 a break before then, then please do let me know. 3 Please remember to try to keep your head up and your 4 voice up so that we can see and hear you clearly, and 5 try not to speak over each other, although we appreciate 6 that's difficult. 7 Finally, as far as the topics list is concerned, you 8 will see that there are indications given in blue as to 9 questions that will be aimed at each of you, but if, at 10 any point, you wish to offer some evidence on what 11 somebody else has said and it looks as if I am moving 12 on, then please do just raise your hand, and I will come 13 to you and ask you some questions. I hope that's 14 sufficiently clear. 15 First of all, Claire Burns, please, can I ask you 16 a few questions, just by way of background. You have 17 provided, Ms Burns, a witness statement to the inquiry 18 with the reference CEL000015. Is that witness 19 statement, Ms Burns, true, to the best of your knowledge 20 and belief? 21 MS BURNS: Yes, it is. 22 MS HILL: Chair, with your permission, I adduce Ms Burns' 23 statement in full. Is that all right, chair? Thank 24 you. 25 Ms Burns, just by way of background, you set out at</p> <p style="text-align: center;">Page 57</p>	<p>1 paragraph 1 of your witness statement several key 2 features of your professional background, but is this 3 right, that, broadly, your experience in relation to the 4 needs of children and families who are in need of care 5 and protection in Scotland has been garnered through 6 a range of different leadership roles over the last 7 25 or so years, and you are currently the deputy 8 executive director of Scotland's Centre for Excellence 9 for Children's Care and Protection, or CELCIS; is that 10 right? 11 MS BURNS: Just one correction there, which is I have 12 recently been made the acting director, due to another 13 secondment. 14 MS HILL: I'm grateful, thank you. But just in terms of 15 the history, at paragraph 1 of your witness statement, 16 we can see further details of your background that 17 illustrates a long history of dealing with these issues; 18 is that fair? 19 MS BURNS: Yes, that's fair, thank you. 20 MS HILL: Turning now, please, to Professor Heffernan, if 21 I may. Professor Heffernan, you have provided a witness 22 statement to the inquiry with reference INQ006360. Is 23 that witness statement, Professor, true, to the best of 24 your knowledge and belief? 25 PROF HEFFERNAN: Yes, it is.</p> <p style="text-align: center;">Page 58</p>
<p>1 MS HILL: Chair, with your permission, I adduce 2 Professor Heffernan's evidence in full. 3 You indicate, at paragraphs 1 through to 6 of your 4 witness statement, that you have a range of different 5 roles. You have worked primarily as an author, writing 6 about issues of management, leadership, organisational 7 culture and ethics, just a couple of the names of books 8 that you have written are "Wilful Blindness", "A Bigger 9 Prize" and "Beyond Measure". You have written for 10 newspapers and journals. You have served as a trustee 11 and board member on many organisations and you are the 12 Professor of Practice at the University of Bath School 13 of Management, and faculty co-lead for the Responsible 14 Leadership programme. You also have experience in the 15 corporate world. Professor, is that a fair, if but 16 short, summary of your background? 17 PROF HEFFERNAN: Yes, it is. I would simply add I have also 18 run five different organisations. 19 MS HILL: Thank you. Finally, please, Mr Marsden, you have 20 given a witness statement to the inquiry with reference 21 INQ005330. Is that true, to the best of your knowledge 22 and belief? 23 MR MARSDEN: It is. 24 MS HILL: Thank you. Chair, I adduce that statement in 25 full, please, if I may.</p> <p style="text-align: center;">Page 59</p>	<p>1 Mr Marsden, you are the managing director of 2 Verita Consultancy, which is a leading independent 3 consultancy for regulated organisations. You specialise 4 in carrying out objective investigations of complex and 5 often sensitive issues in a thorough way. You provide 6 organisations with specialist support and advise them on 7 challenging operational and strategic issues in order to 8 help them evolve and improve, and some of 9 the investigations that Verita has been involved with 10 directly relate to child sexual abuse. Is that, again, 11 a fair, but brief, summary of your background, 12 Mr Marsden? 13 MR MARSDEN: Yes, and other forms of abuse, including 14 adults. 15 MS HILL: Thank you. Can I turn, then, please, to the first 16 broad topic on the topics list, which tries to bring out 17 some key overarching themes. I will perhaps turn first 18 to Ms Burns, if I may. You have given some evidence in 19 your witness statement, Ms Burns, about the independent 20 review of policy and practice in relation to Child 21 Protection commissioned by the Scottish Government, and 22 I think you indicate at paragraph 12 of your witness 23 statement that national and local leadership was 24 identified as one of the most critical factors in 25 creating a system with effective processes and culture</p> <p style="text-align: center;">Page 60</p>

<p>1 to ensure children are protected from abuse and neglect. 2 Just help us, please, Ms Burns, a little more with the 3 details around that. Help us know a little bit more 4 about that finding and why it's said that leadership is 5 so important in child protection? 6 MS BURNS: I think the reason that we know that child 7 leadership is so important is because there are specific 8 leadership behaviours that we know correlate with 9 stronger safeguarding. So if I can just take you 10 through some of them. So leaders who can set 11 a compelling vision based on ethics that everybody can 12 get behind, so, for example, that it's everybody's job 13 to ensure the care and protection of children and 14 adults. They're the people that can ask reflective 15 questions, who can show an interest, can set a culture 16 of curiosity and challenge and role model this. So that 17 becomes even more important in the context of child 18 sexual abuse. They are also people who can undertake 19 and also ensure that their systems have effective 20 supervision and support for the workforce in order to 21 manage the stress and anxiety that's often correlated 22 with sexual abuse. 23 It's really important, as well, that they are open 24 to multiple perspectives and can hear and integrate 25 feedback and that becomes even more important for our</p> <p style="text-align: center;">Page 61</p>	<p>1 chief exec leaders and our leaders really at the top of 2 systems who may not have a care and protection 3 background, who may have come from finance or education. 4 So that ability really to hear diverse perspectives. To 5 be open to engage, empower and listen to staff at every 6 level of the system and to children and families as 7 well. 8 We only know if our policy and our services are 9 working well if we know they're working at every stage 10 and every level of the system, and that children -- and 11 we're also listening to children and families. So one 12 of the things they have consistently told us is, "Your 13 system doesn't respond when I first raise concerns with 14 you. I have to wait until concerns accumulate before 15 you respond". 16 We also know that leaders need to make sure that 17 there is a feedback loop between them and what's 18 happening at all parts of the system. So do they know 19 from middle managers down to front-line, can they get 20 assurances that the way in which they want the system to 21 function is, and can they look at the data and evidence 22 around that to be reassured? 23 So we know -- so that's kind of setting the context 24 as to why the leadership is so important. I think, 25 actually, what -- the reason it's really important that</p> <p style="text-align: center;">Page 62</p>
<p>1 we think about behaviours is we should start to pay more 2 attention to how we recruit and select leaders. Given 3 this set of behaviours, can we recruit to these, can we 4 see they're observable, can we test for these in the 5 recruitment procedures? 6 I think it's in that context that the Child 7 Protection Improvement Plan said we really needed to 8 look at leadership at both a national and a local level. 9 At a national level, they created the National Child 10 Protection Leadership Group, of which I'm a part. But, 11 more significantly, they were thinking about, "How do we 12 support leaders at a local level, particularly chief 13 officers?". 14 So what they have developed is a network of chief 15 officers' groups. So chief officers are the chief 16 executives of local authorities and health boards and 17 police commanders who have particular responsibilities 18 and ultimate responsibility for child protection. It's 19 a role where there's historically been very little 20 support to that role, particularly for those who didn't 21 come from, again, a care and protection background, so 22 the aims of those -- the leadership events was to create 23 a network of chief officers, to create a safe place 24 where they could learn and get support from each other. 25 You will have seen from the evidence as well that one</p> <p style="text-align: center;">Page 63</p>	<p>1 chief officer was able, in a safe space, to reflect on 2 a significant case review where there had been a death 3 of a child, so it was a safe place to be able to talk 4 about that. 5 Specifically, what they were saying was they really 6 needed help nationally and locally to think about what 7 were the new risks, how could they make sure their 8 protection committees were functioning effectively. 9 The other thing I will just finish on is to say it 10 was that process that allowed them to really think about 11 what was an action plan for improvement. So action 12 planning and thinking about what was the data and 13 evidence that was required for them to think about 14 whether those improvements were actually having an 15 impact. 16 MS HILL: Just by way of summary, I think at paragraph 12 of 17 your witness statement you pull together those threads 18 by saying that the purpose of the network you have 19 described is to share good practice and collectively 20 horizon scan for new risks facing children and young 21 people, and you have given some further detail at 22 paragraphs 13 through to 20 of your witness statement. 23 Is there anything else about the utility of 24 the chief officers' leadership network or events that 25 you would like to add?</p> <p style="text-align: center;">Page 64</p>

<p>1 MS BURNS: One other, which is an update from when I did the 2 expert witness account, is one of the additional asks 3 they had was for really good induction materials, 4 particularly for new chief officers. So that's 5 something that's been developed. It's covered issues 6 such as, again, what is their role and function, what 7 does it look like for them to dispense their 8 responsibilities well. It's also looked at how do the 9 range of committees integrate with each other and, 10 again, seminars on what are some new risks around, for 11 example, domestic violence, drug and alcohol issues, so, 12 again, bringing up these kind of emerging risks as well. 13 MS HILL: For completeness, please, I will adduce the Child 14 Protection Improvement Programme that you have 15 mentioned, Ms Burns. That's got URN reference 16 CEL000001. For the note, can I bring up within that 17 document briefly on screen, Danny, internal page _049 on 18 our URN, which is the report internal page _048. This 19 improvement programme, Ms Burns, had a range of themes, 20 but one of the themes it brought out was the need for 21 leadership and workforce development. The chair and 22 panel can perhaps read those key messages on page _049 23 and over into internal page _050, which talked about the 24 actions that flowed from that. 25 We can then also just perhaps note that there are</p> <p style="text-align: center;">Page 65</p>	<p>1 within that report -- we don't need to bring it up -- at 2 internal page _065, a leadership and workforce 3 development map that may be relevant to the chair and 4 panel. 5 Is there anything else from this document itself 6 that you would like to draw out, Ms Burns? 7 MS BURNS: I think just one additional point is that 8 I think, even since then, we are learning a lot more 9 about the facts that we need to bring in. We often just 10 have this for leaders who we automatically think are 11 involved in the care and protection of children, so from 12 social work, from health and education. I think we're 13 learning a lot more that, actually, some of 14 the decisions around what happens around resources, for 15 example, directors of finance, directors of 16 commissioning and procurement, they often hold the power 17 and the leverage in the system, so when we're thinking 18 about networks of leaders, we need to think much more 19 broadly than we do at the moment and about who are the 20 other people who are making decisions about children's 21 services. 22 MS HILL: Finally, Ms Burns, before I come to the other 23 witnesses who are here, at paragraphs 21 through to 32 24 of your witness statement, you pulled out some further 25 themes around, for example, the fact that child sexual</p> <p style="text-align: center;">Page 66</p>
<p>1 abuse is often hidden and the concern to make sure that 2 denial as an issue does not seep into leadership. 3 Do you want to tell the panel a little bit more 4 about that part of your witness evidence and what can be 5 done to mitigate against that risk? 6 MS BURNS: Yes. So in relation to -- I think those are 7 the -- there's adaptive technical and adaptive 8 activities that we need leaders to do. So we need to 9 make sure they have the correct procedures and processes 10 in place, but we also need for them to think about what 11 are the other issues around lost power, denial around -- 12 particularly around child sexual abuse. We need them to 13 feel confident and competent so they have access to the 14 up-to-date evidence, they've got access to the 15 up-to-date data, that they feel comfortable about being 16 upfront about talking about child sexual abuse, that 17 they, themselves, know what are some of the signs of 18 that so that they can then -- they're gaining assurances 19 throughout their system as well that that's what's -- 20 that's getting paid attention to. 21 Again, later on in the evidence, you will see there 22 is some concern from us that, with other emerging risks, 23 such as child sexual exploitation, that it's seen quite 24 separate from child sexual abuse and, as we focus on one 25 thing, we lose a focus on another and, really, for our</p> <p style="text-align: center;">Page 67</p>	<p>1 leaders, it's about saying we need to keep a hold of all 2 of these risks at the same time and also because they 3 don't happen in isolation from each other. 4 MS HILL: Thank you, Ms Burns. Mr Marsden, can I just ask 5 you some questions now about the introductory part of 6 your witness statement. At paragraphs 3 through to 17, 7 you describe several of the investigations that have 8 been carried out by Verita. You refer to the 9 Jimmy Savile investigation and to several other 10 investigations, particularly in the healthcare sector, 11 and also involving a political party. 12 In relation to those investigations, what key 13 leadership failures and lessons learnt do you think we 14 can draw from that experience that your organisation has 15 had? 16 MR MARSDEN: When it comes to Jimmy Savile, I think he, you 17 know, made his sort of entrance to the NHS in the '60s 18 when management structures were almost non-existent, 19 and, you know, that gave him, I think, an opportunity to 20 exploit the organisations that he had an association 21 with. 22 Eventually, you know, he does get, you know, 23 opportunities provided by other managers to go to places 24 like Broadmoor and work there. I think his behaviour is 25 eventually challenged by the advent of Trust status at</p> <p style="text-align: center;">Page 68</p>

<p>1 Stoke Mandeville, where he was very powerful in the 2 National Spinal Injuries Centre, and the arrival of the 3 Trust structure, you know, in the NHS leads to a chief 4 executive eventually challenging him about his behaviour 5 and his status and standing in that particular 6 organisation. So it sort of rather underlines the 7 importance of leadership and it began to sort of dent 8 his position in that particular organisation. 9 MS HILL: Just before you leave that issue, can I bring up, 10 please, on screen, Danny, within Mr Marsden's witness 11 statement INQ005330_002, paragraph 5. Mr Marsden, can 12 I just zone in on what you said at paragraph 5, some key 13 themes you have drawn out there. Your key findings 14 included: those intent on abuse will try to access 15 hospitals or other care environments; hospitals are an 16 attractive environment to abusers; organisations have 17 a continuing weakness for celebrity/people in positions 18 of power; challenging those in authority is not easy; 19 and the management of volunteers is a particular issue. 20 Do you think those are leadership issues of generic 21 application in this field? 22 MR MARSDEN: Yes. I think there are other things that 23 I would say have come out of our work about -- well, 24 themes about failings in organisations, so Trust boards 25 or boards of organisations ignoring early warnings that</p> <p style="text-align: center;">Page 69</p>	<p>1 things are going awry; non-executive directors not being 2 sufficiently inquisitive about things that they have 3 perhaps been told at a board meeting; organisations 4 applying short-term fixes with adverse long-term 5 implications. I suppose, you know, Oxfam is a very good 6 example of that, although it is not in our case book, so 7 to speak. 8 I think, in the case of Ian Paterson, there was 9 a lot of evidence to say that managers fell short in 10 their management of him because of his persistence and 11 determination to do the things that he wanted to do, you 12 know, as a surgeon. I think there's a continuing trend 13 of organisations not sharing information, not being good 14 citizens in their sectors, if you like. So, "I know 15 your front door is open, but I'm not going to tell you". 16 I think we still see quite a lot of that behaviour in 17 organisations; victims sometimes being, strangely 18 enough, supporters of people whose behaviour might be in 19 question -- David Britten is a good example of that. 20 And a very powerful piece of evidence from a recent case 21 that we have been involved in is, healthcare 22 professionals not believing that a colleague could 23 abuse, even after, you know, a conviction, but finding 24 it really difficult to accept the idea that someone 25 could be, you know, so malign as to commit a terrible</p> <p style="text-align: center;">Page 70</p>
<p>1 offence. 2 MS HILL: The chair and panel can read, in due course, 3 through your witness statement you have given further 4 details about the investigations into David Britten, 5 Myles Bradbury, Ian Paterson and then also the 6 Green Party you have described. 7 Is there anything else arising from what Ms Burns 8 has said on these topics, Mr Marsden, that you would 9 like to comment on? 10 MR MARSDEN: No, I don't think so. 11 MS HILL: Professor Heffernan, you have heard the evidence 12 given by both of these two witnesses on this general 13 topic of the importance of leadership and the key themes 14 arising from leadership failures. Is there anything in 15 particular you would like to add? 16 PROF HEFFERNAN: I would add a couple of things. I tend to 17 think of leaders of organisations facing in two 18 different directions. They have to focus inside their 19 organisations to do a number of things. They need to 20 ensure that there is real coherence across multiple 21 disciplines. Very often in organisational life, each 22 department, each discipline, is its own empire. They're 23 often competitive for resources. They often speak very 24 different languages and attract very different kinds of 25 people, and ensuring some coherence in purpose and</p> <p style="text-align: center;">Page 71</p>	<p>1 standards across those groups is a really fundamental 2 internal job, if you like, of leaders. 3 I think it is also important that they ensure that 4 the goals for everybody in the organisation are 5 appropriate goals, and that the incentives that may or 6 may not be attached to those, or indeed threats that may 7 be attached to not achieving them, are fair, realistic 8 and appropriate. 9 I think they need to be extremely circumspect on the 10 use of targets, which, especially if attached to threats 11 or incentives, can become very, very distorting of 12 people's decision-making capabilities. 13 I think they need to ensure that their organisation, 14 or their part of the organisation, has the resources it 15 needs to do what the organisation has committed to do. 16 So where, for example, the organisation has made 17 commitments to certain standards in a volume of work and 18 there simply aren't enough people to do that work at 19 a respectable standard, that would be a failure of 20 leadership. 21 Equally, ensuring that the people concerned have the 22 time they need to do the work that they're committed to 23 and the time they need in a fit mental state. In other 24 words, we understand very clearly now how people's 25 professional performance degrades with exhaustion or</p> <p style="text-align: center;">Page 72</p>

<p>1 distraction, working in places that are distracting or 2 having to multi-task. So it is absolutely a prime 3 leadership responsibility to ensure that the commitments 4 the organisation have made are amply and appropriately 5 and healthily resourced. 6 The last part of this kind of internal job, I think, 7 is to ensure that the people working in the organisation 8 feel safe, they don't feel in a persistent state of 9 threat, and that, therefore, it is a safe and indeed 10 expected part of their work that they will speak up when 11 they feel that any of the things I have just mentioned 12 aren't actually functioning as well as they need to. 13 I think that, you know, good leaders have to be very 14 clear about who is accountable for what. Everybody 15 can't be accountable for everything, or you just get an 16 internal fog. 17 Then I think there's an external piece of 18 leadership, and the first is about ensuring that the 19 standards and knowledge base of the organisation are up 20 to date, so that the organisation isn't falling behind 21 in terms of external research and understanding and that 22 the organisation is appropriately connected to the 23 society that the organisation serves. In other words, 24 it's in tune with standards and expectations of 25 the organisation, because these things are socially</p> <p style="text-align: center;">Page 73</p>	<p>1 generated and they change. So they need to be in tune 2 with what people expect of them and how people view 3 what's good enough versus what's a failure. 4 I think they have a really fundamental task in terms 5 of what I think of as horizon scanning, which is 6 constantly thinking, does the work, does the 7 organisation feel right, does this feel like 8 a productive, safe place to be, does it feel like it's 9 really up to date and current and part of society, as 10 opposed to isolated from it? 11 MS HILL: Thank you very much, Professor. I move on now to 12 the text topic on our list which is that about embedding 13 ethics and values so that they align with policy and 14 procedure. I think you have all been provided with some 15 evidence that -- in fact, part of it has been read to 16 the chair and panel this morning. That is evidence from 17 the Institute of Business Ethics. Just to adduce some 18 of the documents, one of the issues that the witness 19 Dr Peters from the Institute of Business Ethics talks 20 about is how an organisation's ethics can be embedded 21 into its decision making, and I will bring up, please, 22 on screen, if I may, IBE000007, which is the good 23 practice guide from the Institute of Business Ethics to 24 ethics in decision making. Just perhaps to pull out for 25 the panel some key parts of this, if we can go, please,</p> <p style="text-align: center;">Page 74</p>
<p>1 to internal page _007 and scroll in on the box at the 2 bottom of that page, "The IBE's definition of business 3 ethics": 4 "... the application of ethical values, such as 5 integrity, fairness, respect and openness to business 6 behaviour." 7 It goes on to talk about business ethics being about 8 how an organisation does its business and how 9 individuals carry out their roles. Then if we go over 10 the page, please, Danny, to internal page _008, there is 11 a framework for considering ethics in decision making. 12 If you scroll in on the little diagram, underneath that 13 you will see it has four elements of ethics in decision 14 making: context and culture; rigorous reasoning; an 15 ability to apply decisions; and reflection. 16 Just finally on this, as part of that third piece, 17 the ability to apply decisions, can I bring up, please, 18 internal page _012 and scroll in on table 1, which the 19 chair and panel might wish to look over. This was the 20 result of a piece of work to identify the top factors 21 that were most likely to cause people to compromise an 22 organisation's ethical standards. They can see on that 23 list different factors, including things like desire to 24 further one's own career, pressure to meet unrealistic 25 objectives or deadlines, desire to protect one's</p> <p style="text-align: center;">Page 75</p>	<p>1 livelihood, improper training, diminished morale, lack 2 of consequence if caught, need to follow boss's orders, 3 peer pressure, desire to steal from or harm the 4 organisation, and, equally, wanting to help the 5 organisation survive or a sense of loyalty. Those sort 6 of themes. 7 We can take that down, but, broadly, that is the 8 guidance given by the Institute of Business Ethics about 9 how to embed ethics in decision making. On a similar 10 topic, evidence has been given about the purpose and 11 utility of codes of ethics and about how to communicate 12 ethical values. Just before I come to the witnesses, we 13 will perhaps just bring up, please, IBE000012, which is 14 a document about how to communicate ethical values 15 internally. 16 If we just go perhaps briefly, Danny, within that 17 document to internal pages _010 and _011, there is 18 a certain amount of information in there about 19 communicating ethics, about -- we heard from the read 20 evidence this morning I think a little about this, but 21 the Golem effect and the Pygmalion effect are all set 22 out there. The chair and panel can read further on this 23 if they wish. There is perhaps one other part, if we 24 can go back to internal page _009, one of the ethical 25 issues that was brought out at the bottom of this page</p> <p style="text-align: center;">Page 76</p>

<p>1 was the concept of the bad apples, if you like, where 2 there was an explanation given, "Well, it is just a few 3 bad apples", and the quote goes on to say: 4 "It is not just a few bad apples, it is actually the 5 barrel in which they are operating and we need to fix 6 the barrel as well as track down the bad apples." 7 That's just one of the examples given here. Pausing 8 there, can I ask, please, Ms Burns, first of all, do you 9 have any observations on this pool of evidence from the 10 Institute of Business Ethics that I've summarised quite 11 briefly there, but I hope doing fairness to it? Do you 12 have anything that you would like to add on these 13 principles? 14 MS BURNS: Just quickly, I think, to say that the starting 15 point of ethics and values is absolutely right, and then 16 we are working within the organisation to look at 17 improvements. That's where we start, as we start with, 18 "So what are the values and principles that you're 19 trying to embed into the system?". What I would say to 20 you is, though, it's essential but not sufficient to get 21 changes in practice and that's where we need to see it. 22 We need to think about, how do we translate those ethics 23 and principles into what we actually want to see people 24 saying and doing? We need to be able to say -- when 25 I see that behaviour, when I see staff saying and doing</p> <p style="text-align: center;">Page 77</p>	<p>1 something, I therefore know that that ethic has been 2 embedded into a practice and that there's a feedback 3 loop to tell leaders that it's happening. We often hear 4 people talking about, "We need culture change", and then 5 people think, "Well, what brings about culture change?", 6 but culture change is actually, when people start to do 7 and say something different, you get a change in the 8 culture of the organisation. So I suppose my point 9 would just be that they are an essential starting point 10 but will not be effective unless we can actually 11 translate those explicitly into what we are expecting 12 people to say and do so that we can recognise it, we can 13 measure it and we can coach to it as well. 14 MS HILL: One further document I will ask you to look at, 15 Ms Burns, and bring up, please, for the chair and panel, 16 this is the ethical business leadership document, 17 "Setting the Tone", IBE000002. This is really about the 18 role of leaders in modelling ethical values and setting 19 the tone. If we can go, please, to internal page _009, 20 Danny, the executive summary I think fleshes out some of 21 the themes. If we just look at the questions and the 22 answers just very briefly, the question on the left is: 23 "Why is ethical leadership so important?" 24 There's an answer given, but the bold is: 25 "A leader's influence extends beyond the company</p> <p style="text-align: center;">Page 78</p>
<p>1 itself." 2 It goes on to talk about the role of leaders in -- 3 just looking at the bold on the left-hand side -- 4 influencing the internal tone of an organisation. Going 5 over the page, the influence of stakeholders and society 6 as well. This is part of a much wider report about the 7 role of leaders. 8 Ms Burns, is there anything else that you would like 9 to add on that topic of what part leaders play in 10 modelling ethical values and setting the tone? 11 MS BURNS: Yes, I think particularly in the context of child 12 protection, it's how do they set -- it's the way in 13 which they set a compelling narrative that people can 14 get behind, it's often by the use of values and ethics. 15 I think it's about reinstating for staff, often, the 16 reasons they first came into social work or health in 17 the first place that they often feel has been let go. 18 So about supporting families, supporting families where 19 there are difficulties, where there are challenges, 20 about being able to work with them in a way that is 21 trauma informed that helps them get over some of 22 the challenges they face. So I think the statement of 23 ethics and values is about how you get your workforce to 24 really invest in your vision, in your statement, because 25 I think that's often why they came into this work in the</p> <p style="text-align: center;">Page 79</p>	<p>1 first place. 2 MS HILL: Thank you very much. Professor Heffernan, is 3 there anything you would like to add on these broad 4 topics about embedding ethics and values, communicating 5 them and the role of leaders in this field? 6 PROF HEFFERNAN: Yes, just a couple of things. First of 7 all, I think, of the many organisations I've researched 8 and worked in and worked with, I would say that it's 9 very hard to tell when ethics are embedded. You get 10 a lot of posters and a lot of seminars, and I think, in 11 many instances, people regard this as formulaic, banal, 12 meaningless, not relevant to them. 13 The second thing I would say, connected to that, is, 14 we really do understand that ethical thinking is 15 cognitively expensive, which means that you have to be 16 rested, you have to have time to think, and to think 17 clearly, and so, when people are overtaxed, both in 18 terms of their professional work and maybe their family 19 demands, we know from research that people will simply 20 not see that something that is being decided or being 21 done has any ethical dimension. Most people don't 22 understand ethics, ethics are not taught in 23 organisations. What an ethical decision or choice looks 24 like, most people are quite poor at identifying. So 25 I think, in most organisations, the depth of ethical</p> <p style="text-align: center;">Page 80</p>

<p>1 thinking and consideration is painfully thin. You know, 2 to call it icing on the cake would give the impression 3 it's actually thicker than it is. So it's talked about 4 but my experience shows me nobody really knows what 5 anybody is talking about, so they don't really take it 6 seriously. Very few people can really identify ethical 7 moments in decision making. 8 I would also say that whether or not ethical 9 decision making becomes the norm in an organisation 10 depends crucially on the diversity and the leadership in 11 that organisation, which is that if it's all run by 12 people who are roughly the same, roughly the same 13 background or gender or ethnicity or discipline, or 14 whatever, then there will be a failure to take 15 perspectives, because, you know, my ethics aren't the 16 same as yours, they aren't the same as my neighbour's, 17 they aren't the same as my children's, and so ethical 18 errors often occur when what I think is good you think 19 is not, and if we don't have diversity in decision 20 making, we may miss ethical problems because, to us, the 21 situation seems fine, whereas to a different group they 22 might seem deeply problematic. That's not about 23 political correctness; it's understanding that ethics 24 are intrinsically subjective. However rational we may 25 be in thinking and talking about them, they are</p> <p style="text-align: center;">Page 81</p>	<p>1 nevertheless subjective. 2 I would also say that it's really crucial in ethics 3 to find a language to discuss ethical issues which 4 people understand. It's often surrounded by jargon and 5 abstract nouns. You know, you have pages of abstract, 6 you know, vague, undefined concepts which mean nothing 7 to people. If you are going to talk about ethics, you 8 have to talk about situations in which choices have to 9 be made, and who is thinking about whom, and that's 10 rarely the kind of gritty, realistic, recognisable 11 detail in which ethics is discussed. 12 Two other quick points. I remember in the 13 Savile Inquiry into the BBC, Dinah Rose QC made a list 14 of recommendations, one of which was she urged the BBC 15 to go out of their way to recruit individuals with high 16 ethical standards. There is no blood test for high 17 ethical standards. It is impossible to identify who has 18 high ethical standards and who does not. So I think the 19 notion that you have to have particularly good people to 20 make good decisions is at least completely impractical. 21 The last thing that I would say is that, as much as 22 we talk about leaders as though they really have control 23 over their organisations, the truth is that you don't, 24 because the organisations inhabit a wider society, and 25 I might, as a leader of my organisation, wish it to</p> <p style="text-align: center;">Page 82</p>
<p>1 conform to a certain bunch of ethics, but if the social 2 pressure is against those, then I really have no chance 3 of absolutely changing the way that the people who 4 report to me think. 5 If, for example, you are working through a period of 6 very high unemployment and very, you know, extreme 7 economic decline, the pressure exerted by that much 8 bigger context will override a great deal of so-called 9 ethical management, and so I think it is important to 10 understand that no organisation exists in a vacuum. It 11 has all the multiple ethical perspectives of each person 12 working inside them, and it has all the external 13 pressures about public mood, sentiment and economic 14 condition, and that's part of what makes leadership so 15 immensely complex. 16 MS HILL: Thank you, Professor. Mr Marsden, anything else 17 on this topic that you would like to add that's not been 18 covered by your fellow witnesses? 19 MR MARSDEN: Yes, if I could. Carrying out the Savile 20 lessons learnt report for the Secretary of State, 21 Kate Lampard and I visited a lot of Trusts and I would 22 say almost all of them had carried out work on values 23 and, you know, what does this organisation believe, and, 24 as Professor Heffernan said, perhaps done a lot to 25 communicate those values down into the organisation, you</p> <p style="text-align: center;">Page 83</p>	<p>1 know, questionable, I think, how much notice people 2 really took of them. 3 Addenbrooke's is an organisation where 4 Myles Bradbury worked, a large established teaching 5 hospital with values and mission statements and no 6 doubt, you know, safeguarding leads and managers galore, 7 policies galore, but I don't think any of that would 8 have stopped Myles Bradbury from what he did. Perhaps 9 that's another bit of evidence, but I think you have to 10 have those things and they're really important, but, as 11 Professor Heffernan says, the sort of -- the impact of 12 them, in the end, is sort of questionable, but you have 13 to have them, and you should have them, but they won't 14 necessarily prevent things from going amiss. 15 MS HILL: Thank you, Mr Marsden. While I have you, if 16 I may, I'm going to move to the third topic and ask you 17 some questions about some of the key lessons that you've 18 drawn out in your witness statement at paragraphs 18, in 19 particular, through to 24, but also, in fact, through to 20 paragraph 31. 21 If I have put this correctly, I think the three key 22 themes that you have drawn out from the investigations 23 that you have carried out are, firstly, you describe the 24 "someone else's problem" phenomenon, people seeing 25 safeguarding as someone else's problem; second, you talk</p> <p style="text-align: center;">Page 84</p>

<p>1 about safeguarding issues being associated with 2 particular patterns of behaviour, and you've mentioned 3 there the concept of superhero status; and then, 4 thirdly, you have talked about a particularly worrying 5 theme of organisations prioritising their short-term 6 reputation over safeguarding. 7 Those three themes all, perhaps, to varying degrees, 8 feed into this topic of how organisations can stay safe 9 and be effective at being safe. So would you like to 10 just amplify those themes a little bit or help us 11 understand a bit more what you mean about these three 12 different themes? 13 MR MARSDEN: Could I start off by saying something about the 14 behaviour of the individuals who feature in our case 15 book, the cases I have referenced in my witness 16 statement? Those individuals, all of them, share some 17 common characteristics: one, they are very persistent, 18 you know, in their intention of getting their own way; 19 they share the characteristic of being manipulative -- 20 certainly that was true of Myles Bradbury, but also of 21 Ian Paterson and David Britten; and I suppose the third 22 characteristic that I think is a real challenge for 23 organisations is, they're very highly motivated to get 24 what they want, and they're more motivated to get their 25 way than organisations are to stop them.</p> <p style="text-align: center;">Page 85</p>	<p>1 They do share some behaviours that I think provide 2 a sort of breadcrumb trail, if you like, to help with 3 their management. 4 All of those individuals -- Bradbury, Britten, 5 Paterson -- sought to create in their patients, you 6 know, dependent relationships. So where you see me as 7 the person who is your saviour, you know, "I'm going to 8 cure your cancer" or, "I'm going to make your child 9 better from the cancer that they have", or, you know, 10 "I'm going to help you overcome your eating disorder", 11 and they use that relationship to, you know, exploit 12 people, and other professionals -- I think this is true 13 of Addenbrooke's and Myles Bradbury -- sometimes get 14 drawn into thinking along those lines, and question 15 their own abilities and their right to challenge. 16 The second characteristic that they share, which 17 I think is worth drawing to your attention, is, they 18 create the space to operate, and particularly, you know, 19 in the case of Bradbury, say, to abuse, and that can 20 manifest itself in unorthodox working practices. So 21 Myles Bradbury would choose to see patients out of hours 22 and do that in order that he could abuse. People 23 ascribed good motive to that: they thought, "He's a good 24 doctor and he's doing that for benevolent reasons". But 25 this practising alone, you know, is a real clue, along</p> <p style="text-align: center;">Page 86</p>
<p>1 with other behaviours, particularly sort of unorthodox 2 working practices and seeking to create that dependent 3 relationship, I think a real clue to these people's 4 behaviour. 5 MS HILL: Forgive me, those are clues that you have 6 described in your witness statement as being things that 7 managers and colleagues should be quicker at picking up 8 as patterns of behaviour. 9 MR MARSDEN: Absolutely. I think there is something to be 10 said for actually in the NHS, for example, teaching 11 staff about those behaviours. You know, it's not that 12 you should challenge the lone worker, because there are 13 plenty of lone workers in the NHS who are doing a proper 14 job, but it is that bundle of characteristics that 15 provide us with a clue to people's intentions, and 16 those, I think, do need to be more explicitly taught. 17 In fact, we have had discussions with NHS England in 18 the last year or so about actually doing some work along 19 those lines, and I think it would be really worth doing. 20 The question of sort of other response -- you know, 21 who is responsible for safeguarding, I think that 22 certainly in the Green Party I don't know that it was 23 very clear from that investigation who was responsible 24 for safeguarding in the Green Party. I think it is 25 clearer in, you know, bigger organisations, and one of</p> <p style="text-align: center;">Page 87</p>	<p>1 the things I would say from the lessons learnt report 2 that we did into Savile was that probably most NHS 3 organisations had made a lot of progress in terms of who 4 was responsible in the organisation for safeguarding and 5 how was it enacted. 6 MS HILL: I think the broad theme, to pull the threads 7 together that you bring out of your "someone else's 8 problem" piece of your witness statement, is you say 9 that experience tells us that breadth of knowledge in an 10 organisation is as important as its depth. The message, 11 therefore, should be akin to that in relation to 12 terrorism, you say: if you see something you think isn't 13 quite right, tell someone about it. Safeguarding is not 14 something that can be left to the experts. 15 MR MARSDEN: No. 16 MS HILL: On the final topic of prioritising, in the short 17 term, reputation over safeguarding, you believe the 18 important message there is to convey to organisations 19 the unacceptability of that prioritisation. Have I just 20 pulled out the key themes on those topics correctly? 21 MR MARSDEN: Yes, and I think that theme of organisations 22 not being good citizens is one that we continue to see, 23 and I think it absolutely requires challenge. 24 MS HILL: Professor Heffernan, can I come to you, please, to 25 give us your views about this issue of how to ensure</p> <p style="text-align: center;">Page 88</p>

<p>1 that leaders and staff do take personal responsibility 2 for safeguarding, avoiding what I think has been 3 referred to as bystander behaviour. Can you give us 4 your views on those topics, please, Professor? 5 PROF HEFFERNAN: Yes. I think in many complex 6 organisations, it can become very murky as to who is 7 responsible for what, and I think there are two issues 8 here. One is, people often go to great lengths to 9 ensure that they're very clear about what they are 10 responsible for in terms of delivery of work, so they 11 know what their deadlines and goals and targets, and so 12 on, are. 13 Where things are more diffuse, and safeguarding is 14 a classic example, where safeguarding may be the 15 responsibility of one person but it is also a general 16 responsibility of all persons. That's the point where 17 people's sense of what their professional standards are 18 gets very confused. It can even get to the point where 19 everybody knows this and everybody recognises that there 20 are difficult things that nobody really wants to handle, 21 and you can even get a situation where this becomes 22 a kind of a joke. 23 So one example of this would be at General Motors in 24 the United States when one of their cars had a known 25 fault which in some cases causes death, and yet, within</p> <p style="text-align: center;">Page 89</p>	<p>1 General Motors as a whole, there was a great joke, and 2 this is reported by Anton Valukas who did the 3 investigation into General Motors. Everybody made 4 a great joke of the fact that nobody wanted to touch 5 anything difficult, so they had what they called the GM 6 salute, which is, if you say, "Okay, who owns this?" or 7 "Who is going to run with this?", executives would cross 8 their arms and point in opposite directions. In other 9 words, "I'm not doing it, you're not doing it. Ha, ha, 10 ha, isn't this hilarious?", and that can become 11 culturally quite embedded. Nobody called it a person's 12 salute, they called it the General Motors' salute. So 13 you can get a kind of culture where everybody knows what 14 the hot potato is, everybody knows not to touch it, 15 everybody will make jokes about the people who try to 16 touch it and often kind of expel that person -- that's 17 what you saw at Bristol Royal Infirmary when the 18 anaesthetist, Steve Bolsin, tried to raise concerns 19 about a dangerous surgeon. 20 So, you know, there is a political sensibility in 21 organisations around work that's difficult that nobody 22 wants to do, and so, often, the fact that it isn't being 23 done is widely known and often even celebrated. You 24 know, the people who manage to dodge the bullet, you 25 know, it's seen to be a sign of political prowess.</p> <p style="text-align: center;">Page 90</p>
<p>1 So this is about bystander behaviour, in the sense 2 that sometimes it is very conscious and slightly 3 self-serving, but sometimes there's simply an assumption 4 that, well, this is so widely known, it is such an 5 obvious and visible problem, that clearly somebody must 6 be doing something about it. It couldn't possibly be 7 the case that nobody would be doing something about it. 8 So there's an operating assumption that, "I don't 9 need to do anything because clearly somebody is doing 10 something", and that creates a kind of vacuum in which, 11 you know, everybody may -- (a) everybody has a sense 12 that it is well known; they may also feel that talking 13 about the problem among themselves is a form of action, 14 when, in fact, it isn't. 15 So if I'm concerned that there is something 16 difficult going on and I talk to my colleague about it 17 over coffee, we feel we have done something, but in 18 terms of real action that produces an outcome, we 19 haven't. 20 So my work around wilful blindness is about these 21 situations in which everybody knows, people may even be 22 talking about it in the canteen, as again was true in 23 Bristol Royal Infirmary. People have a sense of, well, 24 it's such public knowledge, something must be happening, 25 when, in fact, nothing is happening.</p> <p style="text-align: center;">Page 91</p>	<p>1 MS HILL: Can I just bring up, Professor, while you're on 2 that topic, in your witness statement, 3 INQ006360_001-002. If we can scroll in on paragraph 7, 4 Professor, that straddles both those pages, you talk 5 there about the concept of wilful blindness about which 6 you have written. You describe there this as being 7 a recurrent phenomenon in individuals and institutions 8 where some ethical wrong is persistently overlooked by 9 those who bear responsibility or those who are 10 threatened by that wrong: 11 "I kept seeing the same pattern emerge after each 12 organisational failure. First, everyone said nobody 13 knew or could have known. Then it transpires that a few 14 people knew and tried to do something but which 15 silenced, ignored or punished. Then it turns out that 16 just about everyone knew that there was a major 17 concern." 18 Does that reflect the phenomenon that you are 19 talking about? 20 PROF HEFFERNAN: Yes, and, I mean, these cases crop up in 21 the news on a kind of regular basis. The Volkswagen 22 emission scandals would be another one. They always 23 follow the same narrative, which is, "Gosh, no-one 24 knew", and then, of course, there is always someone who 25 knew, and almost invariably someone who did try to at</p> <p style="text-align: center;">Page 92</p>

<p>1 least pose an argument as to why this was a bad idea. 2 Certainly in the mortgage crisis, in the financial 3 crisis, this was true in really every financial 4 institution that I talked to, a very pervasive sense in 5 every part of the organisation that these were dangerous 6 products that were bad for people and bad for the 7 financial system. So this narrative that, "Well, nobody 8 knew. We couldn't possibly have seen this", to "a few 9 people did know" and then evidence that people not only 10 did know but tried to do something about it, to the 11 sense that, actually, everybody knew, this is the 12 narrative that many, many, many of these cases follow. 13 MS HILL: Thank you, Professor. Just finally, Ms Burns, in 14 the last few minutes before we take our break, in your 15 witness statement at paragraphs 58 through to 64, you 16 have talked about leaders trying to close the 17 implementation gap between initiatives and policies and 18 actual changes in practice on the ground. Perhaps with 19 a particular focus on how organisations can be safe and 20 effective at being safe, is there anything else that you 21 would like to add on that topic or what you have heard 22 from your fellow witnesses? 23 MS BURNS: Just a couple of points. I think there's 24 comparisons that can be made with what 25 Professor Heffernan is saying and bringing that into the</p> <p style="text-align: center;">Page 93</p>	<p>1 context of child protection. In my evidence you will 2 see we talk about this missing middle which is where 3 there's no capacity or response when early concerns are 4 raised either by a family or by workplaces around 5 a family. 6 So in terms of this missing middle, what we are 7 hearing is that health -- other -- universal services 8 were saying, "This situation is actually too difficult, 9 too challenging, for universal services, it is not for 10 us", and you have statutory social work saying, "They 11 have not quite reached the threshold, it is not quite 12 serious enough for us". I think there are comparisons 13 to be made there. 14 In that missing middle, then, you need new 15 functions. If we are going to develop early family 16 support, which is a lot of the values and statements 17 that local authorities will say, I think, again, the 18 evidence that Professor Heffernan gave before is, what 19 we tend to do is we then tend to either layer it on to 20 somebody else's responsibility, so that's -- and that's 21 the first one, so it is just an additional 22 responsibility that somebody has got. 23 I would really like to, in the last couple of 24 minutes, focus in on my evidence around the 25 implementation gap, in that we are always really</p> <p style="text-align: center;">Page 94</p>
<p>1 disappointed that we don't shift the outcomes with 2 a range of initiatives that we try to implement, and 3 I would say that one of the most important things for 4 the committee to consider is that we don't pay enough 5 attention to the evidence around the how of change as 6 well as the what. We often think, if we can identify 7 the right intervention, that's going to be sufficient, 8 so something like family group decision making or 9 significant case reviews. It's not sufficient. We all, 10 as a sector, have very strong mental models around what 11 will make change happen that the evidence doesn't 12 actually support us on. So things like legislation and 13 guidance. So, in Scotland, we have seen a plethora of 14 legislation and guidance. Again, it tends to just layer 15 on and clutter the landscape for the workforces and 16 complicate for them. We have websites, we do guidance, 17 we do train, training the trainers. These things are 18 essential but not sufficient to get the changes on the 19 front-line that we want and we really need to start 20 paying more attention about what are the conditions and 21 the supports that are required by the workforces if we 22 want to see the aspirations in legislation and guidance 23 really be put into practice. One of them is that we 24 have to put in data that measures those practices and 25 says that people are practising as was intended and that</p> <p style="text-align: center;">Page 95</p>	<p>1 they're also having the outcomes as intended. 2 MS HILL: When we return after the break, I will ask you 3 some more questions about management information and 4 some other topics, but, chair, it is 3.00 pm, so could 5 we perhaps take our mid-afternoon break and return at 6 3.15 pm? 7 THE CHAIR: Yes, we will do that, Ms Hill. Thank you very 8 much. 9 (3.00 pm) 10 (A short break) 11 (3.15 pm) 12 MS HILL: Ms Burns, just before we broke you alluded to the 13 topic of management information, so I will just take 14 topic 6 on the topics list if I may now, please. You 15 have given some evidence at paragraphs 33 to 41 of your 16 witness statement about the approach taken with the 17 minimum data set for Child Protection Committees. If 18 I can just bring up the guidance document, please, 19 CEL000011. This is a guidance manual produced last year 20 by CELCIS. If we go, please, to internal page 3, can 21 I just ask you to help take us through this. If we can 22 put pages 3 and 4 side by side. Ms Burns, if I have 23 understood it correctly, what you have set out here in 24 the guidance document are 17 different sources of data. 25 So, in fact, we can put page 2, please, on one side and</p> <p style="text-align: center;">Page 96</p>

<p>1 page 3 on the next, Danny. So it is the table of 17 2 factors, so it is _005 on our numbering but it is page 3 3 of the document. 4 On this table, Ms Burns, if I have understood it 5 correctly, there are 17 different indicators which are 6 different types of data. I think the broad thrust of 7 the guidance here is that, through consultation and 8 development, these sources of information are considered 9 to be the minimum data set for Child Protection 10 Committees. Have I broadly understood that correctly, 11 Ms Burns? 12 MS BURNS: Yes, you have. 13 MS HILL: Just help us in understanding a little bit, 14 please, the significance of this management and order 15 information and why you think it is important for child 16 protection issues? 17 MS BURNS: I think the first general statement is about the 18 fact I think data and the use of data is a real leverage 19 point in the system that we don't maximise. So it is 20 a game changer in how we do children's planning if it is 21 done well. There is currently insufficient focus on 22 data generally that helps us with children's planning, 23 with responding to the needs of children and families 24 because we don't have the confidence or competence in 25 the sector within leaders to look at it, or the</p> <p style="text-align: center;">Page 97</p>	<p>1 technical skills. We also don't have good data systems 2 that allow us to pull the data out that we need or to 3 read across systems as well. 4 To give you an example of this, when we were working 5 on our workaround improving permanence for children and 6 we were looking at key decision making and the delays 7 between decision making, we had to go to individual 8 children's files to find those out. So still, even 9 today, we don't have a system that really helps us to 10 get easy access to the data that we need. 11 In terms of the minimum data set for child 12 protection, it was: what is the most important pieces of 13 data that we need to be able to do children's planning? 14 So, again, there are lots of data sets. It was often 15 what leaders were seeing as -- it was really difficult 16 to see the wood for the trees within them, so how could 17 we help them think it, what was it they really needed to 18 focus their attention on that would allow them -- to 19 help them do their planning kind of internally and on 20 a local basis, but would also help them to benchmark 21 nationally as well. You can see from the others a range 22 of indicators which includes numbers, characteristics of 23 children and families, whether they have been registered 24 or not, other contextual factors, timescales between 25 different decision-making points which are important and</p> <p style="text-align: center;">Page 98</p>
<p>1 also parental involvement as well. 2 I would just say that, you know, we are also trying 3 to do this in a way that is aligned with what I've been 4 saying around the implementation gaps, so we were saying 5 guidance alone wouldn't be sufficient, training alone 6 wouldn't be sufficient. So we have done these things 7 that we are providing regular support at a local level 8 on an ongoing basis to the pilot sites and I think 9 that's been part of the success of that. 10 So it has allowed them to look at the data around 11 their children, but it's also allowed them to look at 12 the effectiveness of the systems around those as well. 13 One of the local areas was saying what was really 14 helpful about it was, it streamlined their reporting, 15 and it also, again, really helped them to focus in on 16 what was the most important data that they needed to pay 17 attention to, and then, again, it helped them think 18 about what was an action plan for improvement and what 19 would be the measurements to demonstrate that they had 20 actually implemented those improvements. 21 MS HILL: Just one example of something a bit more granular 22 that might affect particular children, you have given 23 the inquiry a copy of the Care Inspectorate practice 24 guide to chronologies. Can I just bring this up 25 briefly, CEL000012. I think this document takes</p> <p style="text-align: center;">Page 99</p>	<p>1 practitioners through understanding the importance of 2 chronologies around children. We can go and look, 3 please, on internal page _003, Danny, just so the chair 4 and panel can see the sort of detail that this document 5 goes into. It sets out a series of things that will 6 help practitioners make sure chronologies are more 7 useful, and that's one example of accuracy in data that 8 perhaps has a particular impact on specific children. 9 Is that fair? 10 MS BURNS: Yes. I think the significance -- again, the 11 issue with chronologies, again, is similar to data. 12 Often, either the worker, whoever the worker or lead is, 13 it's really difficult to see the wood for the trees 14 again, in terms of what has been the significant events 15 or the significant timescales or family circumstances 16 that's required for us to make good assessments and do 17 good planning, and, again, often workforce -- key 18 workforces will say to us, "Just tell me what you want 19 me to write in chronologies" and we say, "No, it is 20 actually about saying: how do you pull out the correct 21 information that allows you to make an assessment, that 22 allows you to do the analysis? So it can't be totally 23 prescribed. It is the skill of analysis and assessment, 24 that this gives the framework for it. It's really 25 important in terms of child sexual abuse as well because</p> <p style="text-align: center;">Page 100</p>

<p>1 we are often working without a disclosure, so we are 2 having to look behind some of the behaviours that are 3 happening with the child or the young person. So, 4 again, getting these factors, pulling these factors, 5 together is really important. Again, often what we do 6 is we think about chronologies at the point where 7 something chronic has happened or where we're thinking 8 about taking a child into care or making a decision 9 about permanence and, actually, one of the things about 10 chronologies that we need to be more intentional about 11 is, how do we use them at a much earlier stage to aid 12 planning for that individual child and for their family? 13 MS HILL: I'd like to move back now, Ms Burns, to the 14 related topic within your witness evidence about the 15 value of seeking and listening to the voices of children 16 and families. You indicate at paragraphs 56 to 57 of 17 your witness statement -- if you just perhaps pull up 18 CEL000015_012-013, which talks about the need to 19 strengthen children's voices and participation. You 20 have provided evidence at paragraphs 56 to 57 about 21 that, Ms Burns. Is there anything in particular that 22 you would like to draw out for the chair and panel from 23 that evidence? 24 MS BURNS: Again, I think across the sector there's a real 25 recognition that this is something that we should be</p> <p style="text-align: center;">Page 101</p>	<p>1 doing, it's an ethical issue, it upholds young people's 2 rights. It's a real safety mechanism for children and 3 young people as well, that if we open up dialogue then, 4 if things have happened to them or they have experiences 5 they need to share with another adult, it gives them 6 a way through. 7 It also ensures that we are making a holistic 8 assessment of what's happening because that child and 9 young person will have their own kind of valid 10 experience of family circumstances. 11 So I think, you know, most of the sector is onboard 12 with the fact that this is something that we should be 13 doing and we ought to be doing. Again, this will be 14 subject to some of the difficulties that we have talked 15 about in terms of implementation more generally. In 16 Scotland, we have just had a review of an independent 17 care review which was predicated on the views of 18 children and young people and their families, which 19 I think has been hugely positive, and there is a -- it's 20 clearly anticipated in that that this is something that 21 participation and voice is something that will be 22 embedded in local authorities going forward. I would 23 argue, again, asking people to do that and providing 24 guidance to do that will not be sufficient, they will 25 need support. It's also incredibly skilled work. What</p> <p style="text-align: center;">Page 102</p>
<p>1 we have learned as well is that children and families 2 need support both before they go to a particular 3 meeting, child protection meeting or a hearing, as we 4 have in Scotland, they will need support during it and 5 they will need support after it as well, from people who 6 are trauma informed and can manage that. 7 So it is not something that anybody can do. So 8 I think, again, a real commitment in the sector to see 9 that work move on. It will take support for workforces 10 to do that. 11 I think where we need to pay attention is 12 particularly around more marginalised children, so 13 disabled children, children who are engaged in the 14 criminal justice system, and particularly thinking more 15 and looking at the evidence more around voice when it 16 comes to babies. So what is it about babies and 17 infants, what is it about behaviour that's telling us 18 something, even though, verbally, they can't 19 participate. 20 MS HILL: Just to adduce, please, the independent review of 21 care that you have described, it is referred to as "the 22 promise", CEL000014. 23 If we just perhaps bring up that document, Danny, 24 it's CEL000014. If we scroll to _003, Ms Burns, you 25 have provided this document which indicates -- the</p> <p style="text-align: center;">Page 103</p>	<p>1 thrust of this document being Scotland's promise around 2 a series of topics, but a significant focus is given to 3 the topic of voice, and we can see, if we look 4 internally, please, at pages _030 and _031, have them 5 side by side, please, this summarises, I think, the 6 findings of the review, about the need to ensure 7 children are listened to and meaningfully involved in 8 decision making about their care. 9 Then, perhaps, on a more granular level, if you go, 10 please, Danny, to _033 and _034 and put those side by 11 side, that gives a series of bullet points, Ms Burns, 12 underneath the heading "The way Scotland listens to 13 children, families and the workforce must look vastly 14 different". I'm just pulling a few of these topics 15 together now, but on the topic of speaking up, in terms 16 of members of staff and the workforce, is there anything 17 that you would like to add around that and the role of 18 leaders in particular in encouraging a speak-up culture? 19 That's perhaps the voice of staff? 20 MS BURNS: Yes, absolutely. We will talk about important 21 voices from the front-line, and then we're talking about 22 the front-line, we are talking about children and 23 families and we're also talking about the workforce as 24 well. We need that openness, again, particularly in the 25 context of risk and protection, so the way in which</p> <p style="text-align: center;">Page 104</p>

<p>1 there's an openness in supervision to be able to talk 2 about things that staff are worried about, but also just 3 an openness generally in the system as well; in what 4 ways is the system open to hearing those multiple 5 perspectives and in what ways is it open to hearing 6 about challenge as well? 7 Also, we also know that any intervention that we try 8 and implement in the system will only work as well if we 9 have got those feedback loops that I talked about from 10 all parts of the system, because we can have a good idea 11 but, actually, it will be front-line staff that will 12 know what are the barriers that still need to be 13 unlocked for that to have an impact as intended, and 14 what else is it that leadership need to do to be able to 15 flex the system around that. 16 MS HILL: Finally, Ms Burns, before I turn to your fellow 17 witnesses, you were asked under topic 4 to look at some 18 witness evidence from the Children's Society, from 19 Barnardo's and from the Children's Commissioner. Those 20 particular paragraphs that were flagged for you in their 21 witness statements, is there anything you would like to 22 say in relation to those paragraphs that you disagree 23 with or agree with or that you would just like to 24 comment on? 25 MS BURNS: There is nothing additional, no. I think the way</p> <p style="text-align: center;">Page 105</p>	<p>1 in which we think more intensely about those most 2 marginalised children and I think we have a group of 3 children who are skilled in Scotland now and are used to 4 giving their view, but it needs to be much more 5 holistic. 6 MS HILL: Can I move now, please, to Professor Heffernan. 7 Professor, you have heard me ask questions about those 8 three broad topics, so just by way of reminder, they 9 were about using management information, about achieving 10 openness and listening to the voices of children, and 11 about achieving good communication and escalation of 12 issues by employees. On those three topics, Professor, 13 is there anything that you would like to add? 14 PROF HEFFERNAN: The only thing I would say is, I think it's 15 actually very difficult to create what has come to be 16 known as a speak-up culture, and that's because, however 17 one may create an environment in which that's expected 18 within an organisation, it comes back to a point I made 19 earlier, if the individuals working in that organisation 20 carry a high degree of personal debt, for example, have 21 very large mortgages, if we are living through a time of 22 high unemployment, there is an implicit sense of threat, 23 and leaders in organisations need to be very alert to 24 that. However much you say -- and I have had this 25 experience myself -- "I will never shoot the messenger.</p> <p style="text-align: center;">Page 106</p>
<p>1 My door is always open", by and large, people don't 2 believe it because they have never seen it. If they 3 feel vulnerable in terms of their financial or 4 professional position, it's -- the risk is simply too 5 great. 6 I think it's something I routinely see leaders 7 underestimate, which is, it is not just about them, it 8 is not just about their organisation, it's about the 9 wider world in which everybody has to operate. 10 In terms of management information, I would 11 absolutely echo what Claire Burns has said, which is, 12 the data is necessary but insufficient, because the data 13 will do something that is unavoidable, which is, it will 14 dehumanise the information. When you're looking at 15 data, you're looking at numbers. It becomes 16 progressively easier to dissociate the numbers from 17 vulnerable children, and we know from many criminal 18 systems that the more you can turn people into numbers, 19 the easier it is, at least, to overlook their humanity 20 and, at worst, absolutely deliberately to dehumanise 21 them. 22 So I think it's worth thinking about how one both 23 captures the data, but also reminds the people using the 24 data that you're not talking only about numbers here, 25 you're talking about children's lives.</p> <p style="text-align: center;">Page 107</p>	<p>1 MS HILL: Mr Marsden, anything you'd like to add on these 2 three topics? So it's management and audit information, 3 the voice of the child and the speak-up culture for 4 employees. Anything in particular on those topics you'd 5 like to add? 6 MR MARSDEN: On the voices of children and families, I think 7 it is worth saying that Myles Bradbury's wrongdoing was 8 only exposed by the actions of a grandparent who rang 9 the hospital the day after an outpatient appointment and 10 raised a flag about an examination that he'd carried 11 out. 12 I think there was quite a strong sense from the 13 families that we had contact with and spoke to that 14 their understanding about, you know, professional 15 behaviour and what was appropriate and what wasn't 16 appropriate in a clinic setting, and in a clinic setting 17 like the one he worked in, which was treating children 18 with cancer, wasn't entirely clear to them, and I think 19 there is -- firstly, I think they played a real role in 20 stopping his behaviour, but I think there is more to be 21 done about actually explaining the parental and family 22 role in a clinic when they're receiving a service: what 23 can you say, what can you challenge, what can you 24 expect? I think it's something that probably 25 Addenbrooke's have taken on board, but I think that's</p> <p style="text-align: center;">Page 108</p>

<p>1 something that we could do more about more widely. 2 In terms of the culture, the speak-up culture, or 3 being open, I've got various points I'd quite like to 4 make, but clearly it remains a challenge, but there have 5 been successes. I think -- little is said about 6 Addenbrooke's. When Bradbury came to light, they dealt 7 very quickly with what had happened, and the concerns 8 were reported by an administrator to someone in the 9 team, I think to a nurse, and then went straight up the 10 organisation and Bradbury left that day, never went back 11 to the Trust. 12 A colleague of mine says, "We want to develop our 13 people, we need to develop our people to be meerkats, 14 not ostriches", and I think it is a good point. That's 15 what we want people to do. I think 16 Professor Heffernan's point about, you know, people are 17 cynical about that and unsure, I think there has been 18 a history in the NHS of bad treatment of whistleblowers 19 and people feeling marginalised and losing their 20 careers, and Robert Francis has commented about that, 21 but I think it is a real obstacle, and one that we, as 22 managers and leaders, need to do much to overcome. 23 I said this earlier on, but I will just repeat it 24 for the sake of the record. I think we do need to equip 25 people to understand how predators behave. I think</p> <p style="text-align: center;">Page 109</p>	<p>1 that's something we haven't done enough about, and 2 I don't think we have done enough to really try and 3 understand, you know, how they behave. But I think it 4 is something that we should do. 5 I think we need to really anticipate the risks that 6 we take by giving people, particularly senior 7 clinicians, in organisations a special status, and the 8 consequence of, you know, not challenging their 9 behaviour. 10 I think we need to recognise that organisations 11 often don't respond to weak signals that things are 12 going wrong, and need to be better at that. I think we 13 need to recognise the risks that come from allowing 14 people to operate in isolation. Again, I think that 15 comes back to the -- you know, explaining or sharing 16 with people more widely how predators behave. 17 I think we need to be clear about how service users, 18 relatives and staff are clear about the protection and 19 the safeguarding that they should expect. I think we 20 need to make it safe for people, you know, safer for 21 people, to raise concerns about the behaviour of their 22 colleagues. 23 I think we have talked quite a lot about Bradbury, 24 but it would apply to Paterson and Britten as well. 25 People did know, I'm sure, that things were not quite</p> <p style="text-align: center;">Page 110</p>
<p>1 right. They ascribed a positive -- a sort of a benign 2 motivation to it, but they could have done more, 3 I think, to probably have challenged all of those 4 individuals' behaviour sooner. 5 MS HILL: Thank you, Mr Marsden. That segues to, 6 Professor Heffernan, your evidence I was going to ask 7 you about, about the whistleblower topic. You have 8 given some evidence in your witness statement at 9 paragraph 17 about the different whistleblower 10 narratives. You have talked about, in the first, the 11 person who sees something wrong, feels compelled to 12 speak up and, as a consequence, is punished and 13 destroyed. You say that that's the stuff of movies and 14 drama. 15 The second, the truth teller speaks up, the issue is 16 addressed and the organisation is improved. You say 17 that story is almost never told because the 18 organisations themselves rarely like to admit to 19 a problem, especially once it has been solved. But 20 telling that second good news story, if you like, is 21 crucial. 22 Is there anything else on the issue of responding to 23 the evidence of whistleblowers or external reports, and 24 so on, that you'd like to add, Professor? 25 PROF HEFFERNAN: The first thing I would say, kind of</p> <p style="text-align: center;">Page 111</p>	<p>1 following on from Mr Marsden's evidence, is that I think 2 it's important to understand how intimidating formal 3 institutions and people of authority are, especially in 4 very steep hierarchies. The steeper the hierarchy, the 5 more intimidating they are to those in them, because the 6 people above them have power over them. But also to 7 outsiders, you know, like parents or grandparents. You 8 know, typically, however much those institutions try to 9 be user friendly, they are sources of power and they 10 make people feel afraid. 11 Probably all of us here today are used to dealing 12 with institutions and authority, and we may forget that 13 people who don't deal with sources of power every day 14 are deeply intimidated by them. People are intimidated 15 by their GPs when they go, you know, and want to spend 16 30 seconds more than the allotted time. So this is -- 17 you know, the power of hierarchies to intimidate I think 18 can't be underestimated. 19 I think, as far as whistleblowers are concerned, 20 Mr Marsden is absolutely right: the NHS has a really -- 21 I don't use this word lightly -- diabolical history of 22 its treatment of whistleblowers. I have talked to at 23 least 100, probably more, whistleblowers in my time. 24 I have never seen people psychologically so damaged. On 25 one level, they don't regret what they have done,</p> <p style="text-align: center;">Page 112</p>

<p>1 because they knew it was the right thing to do. But, in 2 many, many instances, their lives have been destroyed by 3 this.</p> <p>4 I mean, I spend a lot of my time talking to people 5 within the NHS and persuading them that when people 6 raise concerns, they do this at considerable risk to 7 themselves, and the knee-jerk response is, "Well, they 8 must have an axe to grind" or, "They're a troublemaker, 9 how can we get rid of them?", which I would say is not 10 at all exclusive to the NHS, but this response is both 11 unhelpful and unrealistic. It is a very, very risky 12 thing to speak up and say, "I think there's a problem 13 with a colleague". It feels risky and it feels 14 unfriendly. Nobody does it, by and large, if they don't 15 have a really compelling reason to do it, and nobody 16 does it without thinking long and hard about it.</p> <p>17 I think the balance of evidence is that, when people 18 take the risky step of speaking up, the very, very least 19 they're entitled to is a really safe hearing.</p> <p>20 The issue about stories being told I think is really 21 fundamental. I mean, I mentor a number of very senior 22 executives of very big, publicly-traded firms, and I am 23 truly astonished at the degree to which even people very 24 high up in these organisations, who have a lot of power 25 and a lot of experience, even they will hesitate to</p> <p style="text-align: center;">Page 113</p>	<p>1 speak ill of a colleague, even when their misdemeanour 2 may be widely known. So they have power and they don't 3 know how to use it. I would say of that two things.</p> <p>4 One, if that is true for people who have power, just 5 imagine how much worse it is for people who feel that 6 they have none.</p> <p>7 The second thing I would say is that, it is crucial, 8 when these people do speak up, to be able to report that 9 the problem got fixed. I have certainly myself worked 10 with individuals who finally, with quite a lot of 11 prompting and rehearsal, dared to call out a problem. 12 When it was fixed, (a) there was a huge sense of relief 13 within the organisation -- "My goodness, you actually 14 can get stuff done here" -- but there was a profound 15 reluctance to talk about the lessons learned, like, why 16 has it taken a certain number of years before this 17 happened?</p> <p>18 Now, the one instance -- and I know there are more, 19 but this is the only one I have direct personal 20 experience of -- which is of a nurse within the NHS who 21 moved from Mid Staffordshire to North Staffordshire 22 named Helene Donnelly, a position was created where she 23 worked very closely with the chief executive as the 24 person to whom you come when you have intractable 25 problems that seem never to get solved. What she said</p> <p style="text-align: center;">Page 114</p>
<p>1 to me was, you know, "Yes, when people brought the 2 problems, we could address them, but the even more 3 important thing was to write it up, to circulate it, to 4 talk about it, to make it clear that, actually, when you 5 dare to raise the issue, that is only way it's going to 6 get fixed, and you can never do that too much".</p> <p>7 First of all, it gives people hope and confidence in 8 their organisation; secondly, it shows that problems 9 keep coming, because that's the nature of organisational 10 life; and, thirdly, it shows that the whistleblower 11 doesn't get shot.</p> <p>12 MS HILL: Thank you, Professor. Finally, Ms Burns, these 13 last two topics that are dealt with together, really, 14 are about both responding to evidence from 15 whistleblowers and Serious Case Reviews, but also 16 responding to other sorts of pressures, such as 17 pressures from the demands of multiple policy and 18 legislative initiatives and things of that nature. On 19 those two topics, Ms Burns, do you want to provide 20 whatever views you have, firstly, perhaps, taking the 21 whistleblower issue, if you want to deal with that? It 22 also covers implementation of Serious Case Reviews, that 23 I think you have dealt with in your witness statement. 24 Do you want to share with the chair and panel your views 25 on that topic?</p> <p style="text-align: center;">Page 115</p>	<p>1 MS BURNS: Yes. To take you to the -- just to say, I will 2 be talking about significant case reviews, because 3 that's the Scottish term, but the equivalent is 4 a Serious Case Review in England and Wales. This was 5 one of the other key issues that was brought up in the 6 child protection systems review and then was then an 7 integral part of the Child Protection Improvement Plan, 8 and it was a recognition that -- a recognition that 9 there had been a number of significant case reviews when 10 there had been -- a child had died or there had been 11 significant harm to a child and consistently we were 12 seeing the same issue being raised, so an issue of an 13 implementation gap again, and also that some of 14 the recommendations just weren't helpful either. So we 15 had recommendations that -- some that were incredibly 16 specific and some which were really open, such as, "Need 17 to improve data". So we also realised that, in the 18 improvement plan, there was a need to pay greater 19 attention to who was actually doing the case reviews, so 20 especially somewhere that's quite small, like Scotland, 21 it was somebody else who had worked in a neighbouring 22 local authority who maybe had a child protection 23 background, so, you know, that was -- in essence, that 24 was the criteria, somebody who had worked within child 25 protection, rather than thinking about what were the</p> <p style="text-align: center;">Page 116</p>

<p>1 propensities, the skills and the experience that we 2 wanted those writers to be. 3 So, as part of the Child Protection Improvement 4 Plan, we looked at what was called the Welsh model, 5 which is a tiered model, which is much more -- has 6 a focus on learning and, how do we actually pull out the 7 learning within these? 8 So what we have been thinking about in Scotland, and 9 we have been part of as well, is that -- thinking about 10 the reviews should be more timely, proportionate and 11 contribute to an ongoing culture of learning, so rather 12 than just talking about what parts of the system need to 13 change; that there should be national standards 14 developed setting out the skills and competencies 15 required for those who are doing the reviews; and there 16 should also be the appropriate involvement of children 17 and young people and front-line practice as well in that 18 process. 19 So we are in that process at the moment. We have 20 been -- one local authority particularly had been 21 trialling that out. There's been some really positive 22 feedback around that, which is that the setting up of 23 a multi-agency review panel with the lead reviewer to 24 start off the process was really helpful. There was 25 learning events for key professionals involved with</p> <p style="text-align: center;">Page 117</p>	<p>1 the child and the family. And that there was, as 2 probably links with the last point, a strong 3 facilitation in a safe and supportive environment to 4 allow people to be very honest about what they thought 5 their misgivings was and where the failings had been. 6 Two things, really, to say around that, is that we 7 think it is really positive to have that level of being 8 explicit about what are the skills and abilities that 9 we're looking for in somebody to write it; that we're 10 really thinking about the learning, that the learning is 11 actionable, and we put measures in to ensure that those 12 are done. I think those are the -- it's like other 13 aspects of implementation, what I would say is we note 14 this also has been aligned with other processes that, if 15 there is practice issues or competence issues, those are 16 also -- there is a space for those to be dealt with. 17 What we are slightly concerned is, in Scotland, what 18 we've decided to do is set out some of the principles 19 that we think this approach should look like and that we 20 will leave some of the autonomy up to local areas to 21 decide how they'll implement that. Some concern that, 22 again, we will go back to having 32 ways of doing things 23 and that it will be -- that will allow local areas to 24 almost kind of pick and choose what aspects of 25 the practice of those principles.</p> <p style="text-align: center;">Page 118</p>
<p>1 Actually, we think they come as a whole. So I think 2 we have a tendency not to want to ascribe to local areas 3 exactly how they do something, and in some ways that's 4 helpful, we have to contextualise it for the local area 5 and the local systems. So, for example, we have some 6 areas where children's education and children's services 7 are in one, sometimes children's services are in with 8 health. So, yes, we have to contextualise it, but we 9 also need to make sure that there's not a kind of almost 10 get-out of, "We will pick and choose some of 11 the principles or effective ways", rather than saying 12 this really comes as a whole. 13 MS HILL: Thank you. I think, Ms Burns, you have already 14 talked, in fact, about the pressures placed on 15 practitioners to do with excessive policy and 16 legislative changes. With that, chair, those are all 17 the questions I have for these witnesses. Perhaps there 18 will be some questions from the chair and panel for you. 19 Thank you very much indeed. 20 THE CHAIR: Thank you, Ms Hill. Yes, we have some 21 questions. I will begin and direct this through 22 Professor Heffernan, but I'm happy to hear from the 23 other witnesses. 24 Questions from THE PANEL 25 THE CHAIR: My question is about whether the nature of</p> <p style="text-align: center;">Page 119</p>	<p>1 potential harm to children, or indeed adults, does it 2 make any difference to those who either choose to turn 3 a blind eye or decide to expose an issue, as opposed to, 4 for example, a loss of profit or reputational risk which 5 may have occurred? 6 PROF HEFFERNAN: It's a very interesting question, and 7 I think there is a difference, and the reason is -- and 8 the difference, I think, is this, which is that, in the 9 world of business, we talk about loss of profit and 10 revenue, and so on, all the time, and it's -- you know, 11 it's very measurable, you can see what it is, you know 12 what it is, it is a sort of objective thing. 13 I think in studying all the many cases of wilful 14 blindness that I have studied, I think what is unique 15 about the sexual abuse of children is, it's simply such 16 a terrible thing to think about. Nobody wants to think 17 about it. Of course it's socially repellent, it's 18 individually repellent, and so I think the impulse to 19 think, "Well, I must be wrong because it's so horrible, 20 it couldn't possibly be right", or, "I just don't want 21 to think about it at all because it's too disturbing", 22 and it may be too disturbing, also, because it unlocks 23 uncomfortable memories or sensations, I think there's 24 a real kind of extra pull to look away. It's just too 25 painful; it's too difficult; it's ugly.</p> <p style="text-align: center;">Page 120</p>

<p>1 THE CHAIR: Thank you, Professor Heffernan. Mr Marsden, 2 Ms Burns, do you wish to comment? Mr Marsden? 3 MR MARSDEN: I think that people probably did know things 4 about Savile's activities. People probably did know 5 things about, or have concerns about, Myles Bradbury. 6 But they were all -- well, Bradbury was -- his 7 motivations and behaviour -- or his behaviour was 8 treated as benign. You know, it was given a good 9 motivation. People ought perhaps to have been more 10 enquiring. And whether they weren't because it's simply 11 too painful and too difficult to recognise the 12 possibility that somebody might be abusing in your 13 service I suppose is an open question. But, yes, 14 I think it is a very difficult issue and I think in both 15 those cases probably more could have been expected 16 earlier. 17 PROF HEFFERNAN: I would add one thing, which is, you know, 18 it is very well understood within medicine this thing 19 known informally as the secret curriculum, which is 20 about the degree to which medical students, first of 21 all, self-select as quite conservative. If you ask 22 medical students at the beginning of their career would 23 they do something that wasn't entirely correct because 24 a consultant asked them to, the majority will say yes, 25 and by the time they'd finished their medical training,</p> <p style="text-align: center;">Page 121</p>	<p>1 more of them will say yes. They will have absorbed 2 a message that, "We are an elite, we stick together and 3 we don't", as someone said about Wisheart, the dangerous 4 surgeon in Bristol, "You don't rat out your mates". 5 I think one of the real difficulties with the sexual 6 abuse of children by people in the medical profession 7 is, it's not just that, as an individual, this is 8 a terrible thing to think about, but it's inconceivable 9 that it should be one of your colleagues. 10 MR MARSDEN: Yes. 11 PROF HEFFERNAN: It is just inconceivable. 12 THE CHAIR: Thank you. Ms Burns, I'm not sure whether this 13 is within the scope of your evidence. Do you have any 14 comment to make? 15 MS BURNS: No, I don't have any additional comment. 16 THE CHAIR: Thank you. Another question concerns something 17 that seems to have emerged in the past few years, which 18 is about the recruitment of people to governance 19 structures, such as boards and committees, and that's 20 the recruitment of people described as disrupters. Do 21 you think this has merit? 22 PROF HEFFERNAN: It's a very difficult question because it 23 begs the question: disruptive of what and of whom? 24 I would say, having sat on, you know, a number of boards 25 of both commercial and charitable organisations, I have</p> <p style="text-align: center;">Page 122</p>
<p>1 certainly personally had the experience where asking 2 difficult questions led to an invitation that I might 3 wish not to extend my term, and I know that others have 4 had a similar experience. This was from individuals 5 who -- by some of the best-educated and most 6 highly-regarded, thoughtful individuals in the country, 7 which is, "Just don't rock the boat". 8 I would like to think that when I have been inclined 9 to rock the boat, it's because I thought the boat was in 10 trouble, not because I find it a thrilling thing to do 11 to ask questions that make other people want me to 12 please leave the room, you know. So I think it's 13 tricky, because I think, if you seek to recruit people 14 who like that kind of opposition, like being disliked, 15 as it were, or who come with a preset ideology about the 16 organisation or the way that it works and regard 17 themselves as isolated crusaders, I think that can be 18 very, very damaging. If they are coming with 19 a preconceived sense of what the organisation is and how 20 they somehow magically know how it needs to be changed, 21 that disruption may not be positive and it may indeed 22 not even be in the interests of the organisation. But 23 I do think that my experience, and I would have to say 24 particularly of charitable boards, is that they 25 generally lack diversity, they generally lack an</p> <p style="text-align: center;">Page 123</p>	<p>1 appreciation that argument/debate/conflict is how 2 organisations think together, and they will, when being 3 questioned, often, you know, kind of stick together 4 against questions, and that, I think, is a persistently 5 troubling aspect of all kinds of corporate governance 6 I've seen both in the UK and the US. 7 THE CHAIR: Thank you, Professor Heffernan. Mr Marsden, 8 I particularly wanted to ask you in relation to this 9 whether the presence of someone with the title of 10 disruptive would have made any difference to the case 11 examples you've been talking about this afternoon? 12 MR MARSDEN: Well, I certainly think that non-executives 13 should challenge. I'm not sure about the wisdom of 14 appointing people to specifically disrupt boards, 15 because I think, in a way, all non-executives should be 16 there to challenge and to ask awkward questions. 17 Certainly when -- I remember going to a board, you know, 18 some years ago and them saying, well, you know, "We 19 didn't really know anything about this before it all 20 blew up", and the answer to that was, "Yes, you did. It 21 had come to a board meeting four years previously", and 22 they sort of look downcast, and you have to say to 23 them -- I remember saying it in terms -- "Your job is to 24 be inquisitive. It is to ask more questions", and I do 25 think it is a critical role for non-executives. I don't</p> <p style="text-align: center;">Page 124</p>

<p>1 think it should be in a disruptive -- as 2 Professor Heffernan says, not in a sort of crusading, 3 "I've got a particular way I want to change this 4 organisation", but I think non-executive directors are 5 there to ask awkward questions, and I've been in plenty 6 of board meetings where that has happened, and it can 7 feel very painful and a bit uncomfortable, but it's also 8 very helpful. 9 PROF HEFFERNAN: I would say, if I may, two other things. 10 One is, if you are the anointed disrupter, you will 11 quickly be tuned out. 12 MR MARSDEN: Yes. 13 PROF HEFFERNAN: I think, in terms of good corporate 14 governance, if you -- I think there is sometimes a value 15 to appointing someone on a particular issue to be the 16 devil's advocate with a disrupter, but that role needs 17 to rotate if people are to take it seriously, and it is 18 a very good exercise in critical thinking and getting 19 boards accustomed to that kind of challenge. 20 I think the other thing that's quite important is, 21 you know, conflict isn't always disruptive; it should, 22 and can be, constructive, which is, you know, "In order 23 to do this better, we need to ask the following 24 questions ...". 25 Equally, I would say that there's a ton of evidence</p> <p style="text-align: center;">Page 125</p>	<p>1 to say that simply asking a question or taking 2 a slightly different position on something can unlock 3 the degree to which everybody else around the table has 4 concerns. So this is a really vital part of any kind of 5 governance. 6 THE CHAIR: Thank you very much. I will ask my colleagues 7 now whether they have any questions. Ms Sharpling? 8 MS SHARPLING: Yes, thank you, chair. This is a question, 9 I think, for Mr Marsden -- it may be 10 Professor Heffernan -- we will see how we go. We have 11 had a lot of evidence throughout the whole inquiry about 12 apologies and acknowledgement towards victims and 13 survivors, and so often we have also heard evidence 14 that, even where a liability may be admitted by the 15 institution, actually attaining an apology from the 16 institution is extremely difficult, and we have heard, 17 in fact, that many of the apologies have actually been 18 given to this inquiry rather than at the time when 19 liability was admitted. I'd be interested in your 20 observations about this phenomenon? 21 MR MARSDEN: My experience of this practice in the NHS, 22 where I think there's been a big, you know, push over 23 the years to get people -- organisations to be more 24 candid, more straightforward, and apologies made, is 25 it's still, you know, very patchy. I mean, I think that</p> <p style="text-align: center;">Page 126</p>
<p>1 people will write letters and people will, you know, 2 offer apologies. Whether those receiving them feel that 3 that is truly, sincerely meant and going to be followed 4 up by action I think is open to question. I've 5 certainly encountered, you know, even in fairly recent 6 times, organisations that resist talking to families 7 about things that have gone wrong at a senior level as 8 well. So I think my experience is that there's quite 9 a lot yet to do on that front, really. 10 MS SHARPLING: Professor Heffernan? 11 PROF HEFFERNAN: It is a very interesting question. 12 I think -- I will come at this from two different 13 perspectives. In the United States in the healthcare 14 system there is generally a kind of rule that you deny 15 and defend, and it's hugely run by lawyers, if I may be 16 so bold, and there is a fear of apology lest it 17 prejudices subsequent investigation. 18 Some very interesting work has been done looking in 19 particular at the University of Michigan healthcare 20 system where they decided to try something different and 21 actually just, when a mistake was made -- because 22 medical accidents are a leading cause of death in the 23 United States -- simply go and explain what happened and 24 apologise and talk about how to put it right. This was 25 widely predicted to bankrupt the system. In fact, it</p> <p style="text-align: center;">Page 127</p>	<p>1 didn't do so. Several excellent things came out of it, 2 chiefly, that the patients who had been harmed tended to 3 recover faster, and they recovered faster partly because 4 they weren't stuck in court cases for years and were 5 able to start thinking about how they would, themselves, 6 recover from the injury, but also they felt respected. 7 I think that, while an apology -- this is my second 8 point, really -- can't undo damage, what it does do, 9 crucially, I think, is restore people's sense of 10 themselves as human beings, which they feel often gets 11 lost in large organisations. This comes back to my 12 point about data. You know, people very often easily, 13 because they often interact with institutions at moments 14 of vulnerability, they often are made to feel 15 dehumanised. They are talked to by people who don't 16 know them, who -- they may see lots of different people 17 whose names they can't remember, they may not even be 18 introduced, there is often no kind of chronology, as it 19 were, to the relationship, and they feel increasingly 20 both harmed and belittled and the belittlement is part 21 of the harm. What the apology does is, it resets 22 a human-to-human relationship and it takes out some 23 degree of the power differential that has happened when 24 an individual confronts an institution. 25 This power differential is part of the harm.</p> <p style="text-align: center;">Page 128</p>

<p>1 MS SHARPLING: That's very helpful, Professor. Thank you. 2 I have one question for Ms Burns, if I may. You have 3 talked, Ms Burns, about the data and how important it 4 is. I was wondering, because there is always a debate, 5 isn't there, between the quality of your data or the 6 qualitative data and the quantitative data and how to 7 get that right balance. But how does a leader, who is 8 probably a senior manager as well as being a leader, as 9 it were, get a clearer line of sight on some of those 10 difficult cases of child sexual abuse, which is why we 11 are here, in the workplace? 12 MS BURNS: I think it's -- so, first of all, we need to be 13 able to -- we need data systems that will allow us to 14 pull both of those things out. So it needs to give us 15 the quantitative and the qualitative data. At the 16 moment, the data systems don't exist that allow us to do 17 that. So, actually, how do we build those data systems? 18 I think one of the real difficulties for us, 19 particularly in social work and in care and protection, 20 is that we don't often want to put the money into 21 something like that. It fees like it's taking money 22 away from families, it's taking money away from what is 23 frontline services. So I think it is something we need 24 to get over, that, actually, investment in things like 25 data is about supporting families, but it can be very</p> <p style="text-align: center;">Page 129</p>	<p>1 difficult to justify that, it can be very difficult to 2 legitimise that to finance departments. And we need 3 skilled people who can go and talk to families and talk 4 to them about what their experience has been and be able 5 to feed that back up, so we need, for example -- in 6 Scotland we have Child Protection Committees, so how are 7 we -- how are leaders regularly asking for the 8 quantitative data, the qualitative data and asking the 9 curious questions about that as well. And does this 10 give them assurances that the system is working as 11 intended or not, and how can they then feed that back 12 down. So I think it really is about -- in Scotland, we 13 have seen it's where the investment has come out of 14 our local authorities, it's come out of things like 15 research data, you know, youth and community work 16 that -- where people who are engaged with those kind of 17 communities. So I think it's, how do we reset the 18 balance of care and put investments into some of these 19 preventative pieces? I think Professor Heffernan made 20 a really significant point about saying that the 21 pressure that the system is under at the moment, it's 22 a real double bind for people at the moment because they 23 have got so little money and we know it is better to 24 invest it earlier, but, at the same time, you have to 25 respond to the risk that is coming through the door at</p> <p style="text-align: center;">Page 130</p>
<p>1 that particular time or the events that have been coming 2 through. I think that's an incredibly difficult place 3 for particularly local authorities to be at the moment. 4 So I think it's also about permissions to be able to 5 invest in that early intervention piece as well. 6 MS SHARPLING: Thank you. Does anybody else want to comment 7 on that? 8 PROF HEFFERNAN: I would simply say -- I think it's exactly 9 right, what Claire Burns has said, about the importance 10 of data. I know that Steve Bolsin, who was the 11 whistleblower in the Bristol babies scandal said that, 12 had they kept better data, they would, years earlier, 13 have been able to identify the extremely high mortality 14 rate in the infant -- in the paediatric cardiac 15 department. So I think this is really crucial, just in 16 terms of saying, "You need to look here. Something 17 wrong is going here", and it won't tell you what it is 18 or how it is, but given that you can't pay equal 19 attention to everything, it will give you a steer as to 20 what questions to ask and where to look. 21 MS SHARPLING: Thank you. 22 THE CHAIR: Thank you, Ms Sharpling. Mr Frank? 23 MR FRANK: Yes, please. Ms Heffernan, if I can begin with 24 you. Going back to the very helpful information you 25 gave us about the subjectivity and the thinness of</p> <p style="text-align: center;">Page 131</p>	<p>1 the ethical veneer, as it were, in some institutions, 2 you, of course -- I appreciate the context, we are 3 dealing with different types of institutions, but we are 4 dealing with institutions specifically dealing with 5 issues relating to crimes against children, and in 6 particular sexual abuse. There is no ethical ambiguity 7 about that. It is a crime. I don't think, in the 8 entire five years of this inquiry, any institution has 9 come to us and said it shouldn't be. So I think we have 10 ethical parity on that. 11 Dealing with the other side of that same coin, which 12 is the ambiguity that may arise when it comes to the 13 reporting of that and the failure of senior leaders 14 sometimes to deal with it effectively, do you think that 15 if, in the balance, there were the consideration that my 16 failure to deal with this adequately would be a serious 17 penalty for me, either in the form of a professional 18 penalty or indeed a crime, that that might just swing 19 the balance in favour of protecting children in the way 20 that we think they should be protected? 21 PROF HEFFERNAN: It is a great question. The short answer 22 is, I don't know. You know, I have certainly known 23 situations where, clearly, criminal activity was going 24 on and it was clear that the individuals who did nothing 25 had a responsibility to do nothing.</p> <p style="text-align: center;">Page 132</p>

<p>1 I think, in terms of child sexual abuse, the issue 2 is much more often a confusion of, is it specifically my 3 job. This is where, you know -- although, of course, 4 you know, car manufacture and the sexual abuse of 5 children are not at all the same, but this is where the 6 problem lies, which is, well, it could also be the case 7 that this is a job for the police or for the social 8 workers or for the GP or for the teachers or for the 9 parents, or for any number of people, and so then 10 there's a kind of governance issue, are you going to say 11 to all of those people, "You are going to be penalised 12 if you don't speak up"? Maybe. It is a very knotty 13 problem. 14 When I think about how in financial services there 15 is a much more personal penalty now, you know, if you 16 don't report accurately. Do I think that that has led 17 to deeper self-scrutiny on the part of the individuals 18 concerned? I probably don't. Because people just don't 19 think it's them. I think the blindness happens, as it 20 were, earlier. Because, honestly, you know, you have to 21 ask yourself, if I am so aware of this that I'm only 22 going to be prompted to act by a fear of retribution, 23 I've kind of lost my way morally, ethically, already. 24 So I'm not sure that it -- I'm pretty confident it 25 doesn't solve the problem. Would it reduce the problem?</p> <p style="text-align: center;">Page 133</p>	<p>1 I don't know. It might just mean people bury it deeper. 2 MR FRANK: Thank you very much. I'm going to ask you, 3 Mr Marsden, the same question, particularly in mind of 4 what you summarised very helpfully in your expression, 5 which was that the perpetrators are highly motivated and 6 often more motivated to commit their offences than the 7 organisations are to stop them. 8 I'm just wondering whether, in the context of that 9 observation, you have anything to say about whether or 10 not having a penalty, in the form of professional or 11 criminal penalty, might make the difference to the 12 organisation being more motivated to stop the offences 13 happening? 14 MR MARSDEN: I think, on balance, I think probably I don't 15 support the idea of penalties. I think it's a sort 16 of -- I'd much rather tackle it from the point of view 17 of, you know, getting boards and organisations to 18 acknowledge the gravity and importance of these issues 19 and tackle them properly. 20 I mean, on an unrelated matter, I'm sort of on 21 a campaign to try and improve the way we investigate 22 patient safety incidents in healthcare and harm to 23 patients, and I think that's, you know, something that 24 people want to do and want to do well, but we need to 25 help them do it better. So I'm sort of not convinced</p> <p style="text-align: center;">Page 134</p>
<p>1 that the sanction would necessarily work. 2 I mean, there are other, you know, sort of sanctions 3 that work, certainly in organisations, I suppose over 4 things like health and safety, you know, whether that 5 would really therefore -- does it motivate people to 6 behave differently? I'm not sure. 7 I think my sort of gut feeling is, I wouldn't go 8 down that road. 9 PROF HEFFERNAN: I think one of the advantages of telling 10 the story of the problem that was righted, which tends 11 to at least provide some glory for the person who raised 12 the issue in the first place, I think that's more 13 compelling in terms of compelling good behaviour than 14 sanctions are productive of stopping bad behaviour. 15 MR FRANK: Thank you. Just for the sake of completeness, 16 can I put the same question to Ms Burns? 17 MS BURNS: I don't think there's an evidence base that would 18 support that that in itself would provide a motivating 19 factor, and I think, again, what we have got to keep in 20 mind here as well is the fear of getting that accusation 21 wrong, regardless of what we see -- you know, regardless 22 of picking up the context, this is -- it feels like it 23 is the most serious thing that you can say about 24 somebody, and it is how do you manage that fear about, 25 if you get that wrong. So what are the processes that</p> <p style="text-align: center;">Page 135</p>	<p>1 are around in organisations that would support you to be 2 able do that in an open way that feels like more of 3 a positive response. 4 MR MARSDEN: Yes. 5 MR FRANK: Thank you. 6 THE CHAIR: Thank you, Mr Frank. Finally, Sir Malcolm? 7 PROF SIR MALCOLM EVANS: Thank you, yes, and in the spirit 8 of discipline, I shall try to limit myself to only 9 two questions, if I may. 10 The first maybe sort of in a way resonates and pick 11 up off some of the things, if I can address you first, 12 Ms Burns, that you were saying in response to my 13 colleague's question. In your statement, you said at 14 one point that too much was dominated by a narrative -- 15 an approach dominated by risk. I couldn't help but feel 16 that that was perhaps resonating in a little of what was 17 being said in the conversation we have just been having, 18 that what people seem to be doing too much is responding 19 to where they see is a risk at all levels, even in 20 reporting, but also in day-to-day activity. 21 Do you think -- I can open this out, and will open 22 it out, to others on the panel too -- there is a way of 23 trying to address these issues which isn't -- obviously, 24 risk must be tackled, but is not so focused on risk. 25 What did you mean by that and what would you think might</p> <p style="text-align: center;">Page 136</p>

<p>1 be the implications of moving away from a risk-based 2 paradigm, you know, perhaps to a "doing what's right" 3 based paradigm? 4 MS BURNS: I think from our work in Scotland, certainly what 5 leaders and people at the -- front-line social workers 6 are saying to us is, "We become very good at detecting, 7 particularly around issues of neglect, and then the 8 removal of those children where we think that's 9 appropriate. What we are not good at, then, once we 10 have removed a child, is thinking about what is the 11 support that that child and that family then needs to be 12 able to overcome that trauma, and then we just see at 13 record keeping, in adult services, those children grow 14 up, the trauma has never been dealt with and we are then 15 dealing with those issues in mental health and 16 addiction". So, in terms of being dominated by risk, 17 I think that's forced the system to be that responsive. 18 I think the other reason is because, actually, there 19 are no services earlier on. We have lost a lot of 20 the preventative services that existed. So the system 21 can only respond with the services that it actually has, 22 which means -- what families are saying to us is, 23 "I tell you at an early stage, or someone tells you at 24 an early stage that there are concerns and the response 25 of the system at the moment is to wait", and it is to</p> <p style="text-align: center;">Page 137</p>	<p>1 wait until there's an escalation of issues and it meets 2 the threshold for statutory social work environment -- 3 for statutory social work intervention, sorry. 4 So I think the very way that we have got the system 5 constructed at the moment pushes us to wait until 6 there's a level -- wait until a particular threshold and 7 risk before we actually intervene, and it is often too 8 late. 9 At the moment, what we are trying to help some local 10 authorities to do is, they are saying it is a vicious 11 cycle of risk because they wait til too long and then 12 things have gone too far with the family and we often 13 have to remove the child, and how do we get back to 14 a virtuous cycle of responding to unmet need in the 15 family at an earlier stage; so how do we shift from 16 thinking about detection and response to risk to 17 thinking about unmet needs at an earlier stage and how 18 do we respond to that unmet need? 19 PROF SIR MALCOLM EVANS: Thank you. Could I ask if 20 Mr Marsden or Professor Heffernan have anything to add 21 to that? 22 MR MARSDEN: I'm not sure I do, actually. 23 PROF SIR MALCOLM EVANS: Fine, yes. Professor Heffernan? 24 PROF HEFFERNAN: The one thing I would say is, the thing 25 I learned in the years that I've spent researching</p> <p style="text-align: center;">Page 138</p>
<p>1 wilful blindness is that people often, exactly as 2 Claire Burns says, think, "Well, I'll ignore it and see 3 what happens", and that feels, at best, quite benign, 4 and, at least, kind of safe. But it isn't safe because 5 what you are doing is, you're giving time and 6 opportunity for the problem to get worse. So it doesn't 7 feel like a negative act, but actually it is. 8 PROF SIR MALCOLM EVANS: Thank you. Perhaps if I could stay 9 with you for a moment and then invite others, if they 10 have any final comments on this. 11 Rightly or wrongly, I was beginning to get a sense 12 from some of the things you were saying that -- this is 13 an investigation on effective leadership of child 14 protection investigation, but do you think there are 15 limits to what we can expect of effective leadership in 16 tackling these problems? Is the question of better 17 leadership becoming something of a bit of a panacea? 18 Obviously, it is very important, but what are your views 19 on that? Are there limits to what we can expect for 20 improved leadership? 21 PROF HEFFERNAN: I think that's a fantastic question. I 22 think it is a bit like education: everything is the 23 fault of education, and education is the cure for 24 everything. I think leadership is often seen as, you 25 know, when things go wrong, it's the fault of</p> <p style="text-align: center;">Page 139</p>	<p>1 leadership, and better leadership is the cure for 2 everything. 3 I think there is quite an interesting body of 4 evidence emerging that leadership is often a lagging 5 indicator of problems. This is, to me, a very 6 interesting and provocative idea; in other words, 7 leaders are often the last to know, and that's in 8 organisations as well as in governments, frankly. 9 Along with that goes a big body of work that shows 10 that there's more information at the edge of an 11 organisation, as it were, than at the top; that leaders 12 are actually so far removed from, if you like, the 13 coalface that it makes it very difficult for them to 14 fulfil all the many, many, many roles that we have all 15 described today. 16 So I think that leadership can be misused as 17 a blanket excuse for why things went wrong, and that's 18 why I tend to believe that, on the one hand, yes, of 19 course you need better, stronger, more competent 20 leadership, which is not that easy to find, frankly, but 21 you also, critically, have to address the more systemic 22 issue, which is creating both systems and a culture 23 whereby it's really easy to say, "I'm a bit worried 24 about this", without feeling that your livelihood is on 25 the line.</p> <p style="text-align: center;">Page 140</p>

<p>1 My own opinion about that is that, if you are going 2 to have an environment where that's an easy thing to do, 3 it's going to be because I have colleagues whom I know 4 and trust -- not the person right at the top of 5 the hierarchy, but people to the left and right of me, 6 where I can ask, "Do you think this is okay? It kind of 7 bothers me", and we can have that frank conversation of 8 trust, and if we all agree that there's a problem, that 9 feels a lot safer, and we can then collectively try to 10 do something about it.</p> <p>11 So I don't think this is an issue only of 12 leadership, but I think creating the environment where 13 those long-term relationships can be developed does have 14 quite a lot to do with leadership, and I would also say 15 that it crucially depends on people being able to work 16 side by side with each other for quite a long time and 17 the casualisation of work, also known as "the gig 18 economy", specifically imperils those relationships of 19 trust.</p> <p>20 PROF SIR MALCOLM EVANS: Thank you. Could I ask Mr Marsden 21 or Ms Burns if they have anything to add to that?</p> <p>22 MR MARSDEN: I would just add, I think, you know, it can be 23 expected and is important that leaders model the right 24 behaviour for an organisation, and, you know, my 25 experience is, what they are concerned about are the</p> <p style="text-align: center;">Page 141</p>	<p>1 things that the organisation is probably going to be 2 concerned about, and what gets ignored by them often 3 becomes acceptable.</p> <p>4 I think the other thing is, you know, leaders should 5 care about the long-term impacts on organisations, 6 rather than simply day-to-day concerns, and, you know, 7 I would -- certainly when I go to organisations where 8 things have gone wrong, you often ask, you know, are the 9 leaders, are the managers, visible within the 10 organisation, and are they actually, you know, finding 11 out what's happening at the front-line, and I think 12 that's where they connect with the organisation -- not 13 that they can be responsible for everything, but they're 14 setting the tone, they're interested, they're trying to 15 resolve problems that impinge upon the work of, you 16 know, healthcare professionals if it's a healthcare 17 organisation. I think that's their role. It can't be 18 everything, but they're setting, you know, the 19 construct, they're providing the sort of framework in 20 which people should be operating.</p> <p>21 PROF SIR MALCOLM EVANS: Thank you. Finally, Ms Burns?</p> <p>22 MS BURNS: I think I would just add, to reiterate the point 23 that's been made, leadership is absolutely essential, 24 but, again, not sufficient in and of itself. One of 25 the concerns that I have is that one of the ways in</p> <p style="text-align: center;">Page 142</p>
<p>1 which we try and manage or try and support leadership is 2 through different leadership programmes. I know in 3 Scotland we have got some leaders who are doing 4 a collective leadership programme and some leaders who 5 are doing, you know, leadership and integration. But, 6 actually, there's no coherence and alignment around what 7 the range of leaders in a particular local authority are 8 saying. It is leadership to some end, to a particular 9 approach. I worry about this isolation of people being 10 on different courses, getting different qualifications 11 around leadership, again, which may -- you know, it may 12 add, it may raise awareness, but it's the coordination 13 alignment that I think Professor Heffernan talked about 14 that is the critical task here for leaders.</p> <p>15 PROF SIR MALCOLM EVANS: Thank you. Thank you very much.</p> <p>16 THE CHAIR: We have no further questions. Thanks to all the 17 panel members for your evidence. Thank you.</p> <p>18 (The witnesses withdrew)</p> <p>19 MS HILL: Chair, before we finally close proceedings today, 20 can I very briefly just formally adduce some 21 documentation? As you will remember, we have often done 22 this in the hearings. Can I formally adduce, please, by 23 way of exhibits provided by Ms Burns, the exhibits with 24 reference CEL000001, CEL000004, CEL000005, CEL000011, 25 CEL000012 and CEL00014 and from Dr Peters from the</p> <p style="text-align: center;">Page 143</p>	<p>1 Institute of Business Ethics the exhibits with 2 IBE000002, IBE000003, IBE000007 and IBE000008. 3 Thank you very much, chair. That concludes the 4 evidence for today.</p> <p>5 THE CHAIR: Thank you very much, Ms Hill. 6 (4.26 pm) 7 (The hearing was adjourned to 8 Tuesday, 8 December 2020 at 10.00 am) 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p> <p style="text-align: center;">I N D E X</p> <p>Welcome and opening remarks by THE1 CHAIR Opening statement by MR ALTMAN4 Opening statement by MR GULLICK30 Summary of statement of DR IAN39 PETERS MBE (read) MS CLAIRE BURNS (affirmed)56 PROFESSOR MARGARET HEFFERNAN56 (affirmed) MR ED MARSDEN (affirmed)56 Examination by MS HILL56 Questions from THE PANEL119</p> <p style="text-align: center;">Page 144</p>

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