

<p>1 Tuesday, 26 September 2017 2 (10.00 am) 3 Welcome by THE CHAIR 4 THE CHAIR: Good morning to everyone. I am Alexis Jay and, 5 as you know, I am the chair of the Independent Inquiry 6 into Child Sexual Abuse. 7 May I also introduce the other panel members 8 present: Ivor Frank, Professor Sir Malcolm Evans and 9 Drusilla Sharpling. 10 The topic of today's seminar is understanding 11 current approaches to the prevention of child sexual 12 abuse in healthcare settings. I am very pleased to 13 welcome all those who have agreed to take part to assist 14 us today, and also to see some familiar faces in 15 attendance in the public gallery. 16 I want to say something about where the seminar sits 17 within the inquiry's work programme, which I set out in 18 my review in December of last year. Today's seminar 19 sits within a wider programme of inquiry seminars 20 designed to gather information and views on a range of 21 important topics. 22 Seminars make a valuable contribution to the 23 inquiry's work. Although they cannot be formal 24 evidence-gathering sessions, the information we hear 25 during them helps us in a number of ways. For example,</p> <p style="text-align: center;">Page 1</p>	<p>1 video, in which we will hear the experiences and views 2 of people who have experienced child sexual abuse within 3 a healthcare setting or by a healthcare professional. 4 I would like to take this opportunity, on behalf of 5 myself and the panel, to thank all of those who have 6 chosen to share their experiences with us. 7 We are pleased that representatives from such a wide 8 range of organisations are present today, and the panel 9 and I will be listening to the discussions with interest 10 and, as I have said, the views and information shared 11 with us will go on to inform the inquiry's future work. 12 So thank you all for agreeing to take part. 13 It is important to remember the purpose of 14 the seminar is not to gather evidence in a formal or 15 legal sense, and Ms Riel Karmy-Jones QC, who is one of 16 the inquiry's counsel team, will be facilitating our 17 discussions today and tomorrow. She will say more about 18 the format of the seminar and its parameters in 19 a moment. 20 The seminar is being live streamed over the internet 21 with a short delay to allow those who are unable to 22 attend in person to follow the proceedings. Once again, 23 my thanks to all of you here who are participating and 24 to those who have taken the trouble to be present today 25 in the public gallery.</p> <p style="text-align: center;">Page 3</p>
<p>1 it helps us to identify areas that require further 2 investigation and scrutiny, and it assists us in 3 gathering current opinion on the matters which the 4 inquiry is considering, including the opinions of those 5 whose work or experiences give them a frontline 6 perspective on the issues. 7 This is the fifth seminar in the programme, which 8 will be spread across a day and a half of sessions. 9 Throughout the seminar, we will seek to focus on the 10 effectiveness of current arrangements to prevent the 11 sexual abuse of children in healthcare settings, and, 12 secondly, the opportunities to make sure that children 13 who receive healthcare and treatment are best protected 14 from sexual abuse. 15 My fellow panel members and I are very conscious 16 that in the time we have we will only be able to skim 17 the surface of the topics for discussion. We hope that 18 what we hear today and tomorrow will help to shape the 19 focus of the inquiry's future work in this area. 20 Given the range and breadth of topics which we will 21 be considering, we will need to use the time well and 22 address the topics in hand as thoroughly as we can. To 23 that end, the panel and I are looking forward to an 24 open, ordered and respectful discussion. 25 This morning's session will begin with a short</p> <p style="text-align: center;">Page 2</p>	<p>1 I will now hand over to Ms Karmy-Jones to start 2 proceedings. Thank you. 3 Session 1: Opening remarks by MS KARMY-JONES 4 MS KARMY-JONES: Thank you, chair. As the chair said, my 5 name is Riel Karmy-Jones. I am a barrister, and I am 6 instructed as one of the lead counsel to the inquiry. 7 One of my areas of expertise is in criminal cases 8 involving sexual abuse, and particularly cases where the 9 victims are particularly vulnerable or they are 10 children. So I am very conscious of the different ways 11 abusers seek to manipulate and control those who are not 12 in a position of power, and the long-lasting impact that 13 child sexual abuse can have on victims and survivors. 14 My role today, however, is simply to facilitate this 15 seminar, and, as part of that, to try to keep things 16 running as smoothly as possible, to help to encourage 17 friendly discussion and, we hope, a lively and candid 18 debate, and possibly also to draw out where differences 19 of opinion may lie. 20 Can I at this stage introduce Rebecca Chaloner, who 21 sits over here, who is the director of the health 22 portfolio; Jennifer Byrom, who sits next to me, who is 23 the health policy lead, together with Patrick Harrison 24 and Bethany Atkinson, health policy and engagement 25 officers. Bethany is at the end and Patrick is sitting</p> <p style="text-align: center;">Page 4</p>

<p>1 in the gallery over there.</p> <p>2 They are the people who have been responsible for</p> <p>3 the preparation and organisation of this seminar, and</p> <p>4 Rebecca, Jennifer, Patrick, Bethany, can I thank you all</p> <p>5 in advance for all the very hard work you have put into</p> <p>6 this.</p> <p>7 We also have in this room Kathy and Heather, who are</p> <p>8 the ushers, who will help us through the day, and Lee,</p> <p>9 who is the hearing centre manager, and Sue, the deputy</p> <p>10 hearing centre manager, who spoke to us earlier. Any</p> <p>11 problems, please revert to them.</p> <p>12 Now, the chair has made reference to the inquiry's</p> <p>13 remit. I just want to set today and tomorrow --</p> <p>14 tomorrow, which is a half day -- into some context by</p> <p>15 referring and reminding those present of the inquiry's</p> <p>16 terms of reference.</p> <p>17 The terms of reference are these: to consider,</p> <p>18 amongst other things, the extent to which state and</p> <p>19 non-state institutions have failed in their duty of care</p> <p>20 to protect children from sexual abuse and exploitation;</p> <p>21 the extent to which those failings have been addressed;</p> <p>22 to identify further action needed -- we are hoping to</p> <p>23 deal with some of that today; to address any failings</p> <p>24 identified; to consider the steps which it is necessary</p> <p>25 for state and non-state institutions to take in order to</p> <p style="text-align: center;">Page 5</p>	<p>1 of life, there are those who seek to manipulate, control</p> <p>2 and abuse the vulnerable in their care. We have seen</p> <p>3 this in the Savile investigation, which, as everyone</p> <p>4 here knows, began with the ITV "Exposure" programme in</p> <p>5 2012 and resulted in Operation Yewtree; we have seen it</p> <p>6 in the Dr Myles Bradbury investigation in 2014, and many</p> <p>7 others.</p> <p>8 As the chair said in her opening comments, we have</p> <p>9 a limited amount of time for this seminar. There is an</p> <p>10 agenda, which the public in the public gallery should</p> <p>11 have on their seats, and this seminar has been</p> <p>12 specifically designed to look at how we can best work</p> <p>13 together across agencies to prevent child sexual abuse</p> <p>14 because the inquiry wishes to understand the current</p> <p>15 arrangements in the health sector and the opportunities</p> <p>16 for improvement; to gather information and views from</p> <p>17 health organisations and professionals about what they</p> <p>18 currently have in place to protect children and, again,</p> <p>19 the scope for improvement.</p> <p>20 So we have brought you together, a number of</p> <p>21 representatives from different agencies across the</p> <p>22 country, and we hope to explore a range of topics,</p> <p>23 really focusing on what your views are of</p> <p>24 the effectiveness of the current arrangements in place</p> <p>25 and what you see as being the major opportunities to</p> <p style="text-align: center;">Page 7</p>
<p>1 protect children from such future abuse; and, in due</p> <p>2 course, to publish a report with recommendations.</p> <p>3 So we hope that what we hear today will go some way</p> <p>4 to assisting the inquiry to deal with some of those</p> <p>5 issues.</p> <p>6 The inquiry set out to investigate whether public</p> <p>7 bodies and other non-state institutions in England and</p> <p>8 Wales have taken their responsibility to protect</p> <p>9 children from sexual abuse seriously and to make</p> <p>10 meaningful recommendations for change.</p> <p>11 As you know, the purpose of this particular seminar</p> <p>12 is to look at child sexual abuse within the healthcare</p> <p>13 setting, something that many find extraordinary, very</p> <p>14 difficult to fathom, and hard to accept, because aren't</p> <p>15 we all, as children, taught to trust our doctors, our</p> <p>16 nurses, our healthcare practitioners, to believe that</p> <p>17 they know best. Often -- usually, even -- that is</p> <p>18 undoubtedly correct. So it is understandably difficult</p> <p>19 to come to terms with what is such a serious breach of</p> <p>20 trust, particularly when there are so many good and</p> <p>21 caring practitioners, staff members, even volunteers,</p> <p>22 who give freely of their time out there.</p> <p>23 But in recent years, we have all become increasingly</p> <p>24 aware that this is not always the case, and that within</p> <p>25 the health sector, just like other professions and areas</p> <p style="text-align: center;">Page 6</p>	<p>1 better protect children.</p> <p>2 In preparation for today, a paper has been</p> <p>3 circulated to a large number of health sector</p> <p>4 organisations -- I think in the region of 50 -- across</p> <p>5 England and Wales, seeking views on these and other</p> <p>6 matters, and in response, the inquiry received a number</p> <p>7 of very helpful and detailed submissions, which have not</p> <p>8 only served to help us shape the agenda for today, but</p> <p>9 will also support the inquiry's further detailed</p> <p>10 consideration of this topic in the future. So thank you</p> <p>11 to those organisations and individuals, most of whom --</p> <p>12 including those who are represented here, I think most</p> <p>13 people here have provided written submissions in advance</p> <p>14 of today.</p> <p>15 I am now going to ask those who sit around the</p> <p>16 horseshoe, our participants, to please introduce</p> <p>17 yourselves, and, as Sue said at the outset, when you do</p> <p>18 so, could you please tell us who you are, whom you</p> <p>19 represent, or if you are here on your own, and just</p> <p>20 explain why you are here and what you hope to achieve or</p> <p>21 gain from this seminar. Please remember the mic does</p> <p>22 need to be turned on and off and it does make quite</p> <p>23 a difference. It won't pick you up if it is far away</p> <p>24 from you.</p> <p>25 So if we could start over with Anthony.</p> <p style="text-align: center;">Page 8</p>

<p>1 Introductions</p> <p>2 MR OMO: Thank you. I am Anthony Omo. I am the director</p> <p>3 and general counsel for fitness practice at the GMC, the</p> <p>4 General Medical Council. In terms of what I hope to get</p> <p>5 out -- I really hope to contribute to the debate and to</p> <p>6 see if there is anything we can do over and above what</p> <p>7 we currently do to assist the inquiry, and to make sure</p> <p>8 that healthcare professionals do what they have trained</p> <p>9 to do and what most of them do, which is provide safe</p> <p>10 care for patients, all patients.</p> <p>11 MR HEANEY: Good morning. My name is Albert Heaney. I work</p> <p>12 for the Welsh Government. I am the director of</p> <p>13 the social services and integration, and I hope to</p> <p>14 contribute today around the safeguarding issues about</p> <p>15 multi-agency working and also our legislation framework</p> <p>16 within Welsh context.</p> <p>17 MS BRAITHWAITE: Good morning. I am Christine Braithwaite.</p> <p>18 I am the director of standards and policy for the</p> <p>19 Professional Standards Authority, our organisation</p> <p>20 overseas, nine professional regulators in the UK, so</p> <p>21 what is like the General Medical Council. We also have</p> <p>22 a role in relation to unregulated healthcare workers in</p> <p>23 the United Kingdom as well. I hope to contribute today</p> <p>24 to discussions around health professionals and the roles</p> <p>25 of regulators in that, and also to take account of</p> <p style="text-align: center;">Page 9</p>	<p>1 understanding of health professionals, understanding of</p> <p>2 safeguarding, but also around their role and</p> <p>3 responsibilities in early identification and support</p> <p>4 with the safeguarding of children agenda, but also CSA.</p> <p>5 MS CHRISTODOULIDES: Hello. My name is</p> <p>6 Helen Christodoulides. I am a director of nursing at</p> <p>7 Leeds Teaching Hospitals Trust. I have been a nurse for</p> <p>8 30 years. I'm an adult nurse by background. In our</p> <p>9 organisation that employs 17,000 staff, I am responsible</p> <p>10 for safeguarding, which is quite a new position for me.</p> <p>11 I line manage head of safeguarding. Since I have been</p> <p>12 doing that in the last ten months I have learnt a lot,</p> <p>13 and I hope to learn more today and tomorrow, and I hope</p> <p>14 that I can contribute by explaining, should it be</p> <p>15 required, what it is like to work in a busy acute</p> <p>16 hospital with many, many patients and many, many staff</p> <p>17 and being able to enact some of the recommendations that</p> <p>18 we might consider would be appropriate.</p> <p>19 MS BEAUMONT-WOOD: Good morning. Rhiannon Beaumont-Wood.</p> <p>20 I am executive director of quality, nursing and allied</p> <p>21 health professionals in Public Health Wales, but I am</p> <p>22 here today representing Nurse Directors Wales. My</p> <p>23 background before the role I'm in was very much head of</p> <p>24 safeguarding in a number of settings, including the</p> <p>25 Welsh Ambulance Service and formerly the Swansea NHS</p> <p style="text-align: center;">Page 11</p>
<p>1 the views that I hear during this inquiry, because we</p> <p>2 are due to review and revise our own guidance on</p> <p>3 managing professional boundaries.</p> <p>4 MR McMORROW: Good morning. I am Ray McMorrow. I am here</p> <p>5 representing the Royal College of Nursing. In my day</p> <p>6 job, I am the health lead for an organisation called the</p> <p>7 NWG who work specifically around supporting the</p> <p>8 multi-agency network around child sexual exploitation.</p> <p>9 I am the health lead for that organisation, so I am both</p> <p>10 hoping to bring our knowledge to the table today, but</p> <p>11 also that we are a multi-agency organisation for driving</p> <p>12 change forward as well and supporting organisations in</p> <p>13 change. I am, by background, a designated nurse and</p> <p>14 a children's mental health nurse.</p> <p>15 MS WARBURTON: Hello, I am Susan Warburton, head of</p> <p>16 safeguarding for NHS England. What I hope to do today</p> <p>17 is to share with you some of the work that we have done</p> <p>18 in NHS England over the past five years and also to</p> <p>19 contribute to the debate about what we need to do going</p> <p>20 forward, because we have made some steps but we have</p> <p>21 much more to do. Thank you.</p> <p>22 MS CUPID: Hello. I am Clarisser Cupid and I am here in my</p> <p>23 capacity as a designated nurse for safeguarding</p> <p>24 children. I work at Southwark Clinical Commissioning</p> <p>25 Group and I am here today to contribute around</p> <p style="text-align: center;">Page 10</p>	<p>1 Trust. We also have within Public Health Wales the</p> <p>2 national safeguarding team which provides leadership to</p> <p>3 NHS Wales to drive forward through a networked approach</p> <p>4 with our health boards and other NHS bodies in improving</p> <p>5 our safeguarding arrangements. So I hope that we can</p> <p>6 share some of our learning from the Welsh context and</p> <p>7 understand the best of what England -- and perhaps</p> <p>8 sharing the practice so we can have -- increase our</p> <p>9 collective arrangements across certainly England and</p> <p>10 Wales, but maybe the UK. Thank you.</p> <p>11 MR DEAN: Good morning. My name is Simon Dean. I work for</p> <p>12 the Welsh Government. I'm the deputy chief executive of</p> <p>13 NHS Wales. So I'm a generalist manager by way of</p> <p>14 background, primarily the NHS, but currently a civil</p> <p>15 servant. My main responsibilities are the interface</p> <p>16 between government and the NHS in terms of planning and</p> <p>17 performance, so I'm looking to work alongside my</p> <p>18 colleagues to contribute to the discussions and to take</p> <p>19 the learning back into my work setting.</p> <p>20 DR STEELE: Good morning. I am Alison Steele. I'm</p> <p>21 a paediatrician and I'm representing the Royal College</p> <p>22 of Paediatrics and Child Health today. For many years,</p> <p>23 I have been a designated doctor for safeguarding</p> <p>24 children and looked after children in the north-east of</p> <p>25 England, in Newcastle, but this last year I'm actually</p> <p style="text-align: center;">Page 12</p>

<p>1 based at Great Ormond Street Hospital as their named 2 doctor. Clinically, I have worked for many years in 3 working with and assessing children who have been 4 victims of sexual abuse and assault, including working 5 within the SARC, mainly for the north-east, paediatric 6 SARC, which is based in Newcastle. I also am a member 7 of the RCPCH Standing Committee for Child Protection and 8 chaired the RCPCH working party which wrote the sexual 9 abuse service recommendations.</p> <p>10 In terms of today, I'm here to learn. I want to 11 hear everyone's views. I would like to take that back 12 with me to the workplace and into the RCPCH in terms of 13 how we better prevent sexual abuse in healthcare 14 settings.</p> <p>15 MR LUCAROTTI: Good morning. My name is John Lucarotti. 16 I'm from the Nursing &amp; Midwifery Council, the UK 17 regulator for nurses and midwives. My role there is 18 head of policy and legislation, especially in relation 19 to fitness to practise where obviously some of these 20 matters do end up. In terms of what I want to 21 contribute today, it's both understanding where the gaps 22 are and also contributing to the ongoing debate.</p> <p>23 MR DENHAM: Good morning. I am Giles Denham. I work for 24 Health Education England. My current role there is 25 director of strategic relationships. My background is</p> <p style="text-align: center;">Page 13</p>	<p>1 subject and we would like to find the means of improving 2 general practice awareness and of improving consistency 3 of delivery of education in this very important area 4 right across the country.</p> <p>5 DR PRICE: Good morning. I am Lorna Price. I'm 6 a designated doctor in the national safeguarding team in 7 Public Health Wales.</p> <p>8 I'm also a community paediatrician. I have been 9 working in safeguarding for more than 20 years, formerly 10 a named doctor in a large health board, where I still 11 work in assessing children who have been abused and 12 neglected.</p> <p>13 I am here to share the good practice that we have in 14 Wales and to learn from the good practice that you 15 have -- that hopefully I will hear about from England as 16 well. I also sit on the Royal College of Paediatrics 17 and Child Protection Standing Committee along with 18 Alison.</p> <p>19 Session 1: Opening remarks by MS KARMY-JONES (continued) 20 MS KARMY-JONES: Thank you all very much, and welcome. We 21 are very grateful to you all for attending.</p> <p>22 Can I just say that we did look for and were rather 23 disappointed to find that there didn't appear to be 24 a survivor group specifically aimed at those who were 25 sexually abused as children within the healthcare</p> <p style="text-align: center;">Page 15</p>
<p>1 as a government policy maker and also as a healthcare 2 manager.</p> <p>3 My particular interest, as Health Education England 4 is within England, a national education and training 5 body, commissioning and providing, is obviously to learn 6 as much as possible about other organisations and their 7 work and how we can contribute on the national front in 8 what we do through education, training and provision and 9 already have done in some respects already.</p> <p>10 DR TIWARI: Good morning. I am Vimal Tiwari. I am 11 a practising GP here representing the Royal College of 12 General Practitioners. We are a membership 13 organisation, over 60,000 members. I am a practising GP 14 and also named safeguarding GP with a very strong 15 interest in child health and a parallel career in 16 community paediatrics. I have been working in child 17 protection and child safeguarding for over 20 years now. 18 I am here because my college takes child safeguarding 19 very seriously. My various predecessors in the college 20 have worked very hard to improve general practice 21 education in child abuse and neglect. We have produced 22 a certain number of educational tools over the years, 23 the most recent being the 2014 edition of the RCGP/NSPCC 24 Child Safeguarding Toolkit. We are aware that there are 25 inconsistencies and deficiencies in GP education in this</p> <p style="text-align: center;">Page 14</p>	<p>1 setting. So if, at the break, anyone is aware of such 2 a group, we would be very grateful for you bringing it 3 to our attention and identifying it to us.</p> <p>4 A little bit more talking from me, I'm afraid, 5 before we get onto the substance of why we are here. 6 Can I set out some limitations and restrictions? There 7 are a number of things that we aren't going to deal with 8 in this seminar, a number of topics we won't look at, 9 because we do have only a day and a half. Amongst those 10 are the role that the health service organisations and 11 professionals may play in responding to disclosures of 12 abuse that have happened elsewhere, for example, in the 13 home or another institutional setting, and in detecting 14 and responding to signs and symptoms of abuse that have 15 happened elsewhere.</p> <p>16 Equally, we are not focusing in this seminar on the 17 therapeutic role of health services in supporting 18 victims and survivors in these discussions. That was 19 part of the focus of the seminar that we had in July. 20 Of course, they are all important. They are all 21 important and relevant parts of the role the health 22 system plays in protecting children, but they are not 23 within the scope of our discussions today.</p> <p>24 We have got a lot of ground to cover, some more 25 restrictions and some more guidance on the approach that</p> <p style="text-align: center;">Page 16</p>

<p>1 we are going to take. As the chair has already said,                  2 this is not a legal or formal evidence-gathering                  3 process. It is not the place for cross-examination or                  4 interrogation, so please bear that in mind. It is not                  5 about levelling criticisms at any specific organisation                  6 or individuals, although we may want to explore or even                  7 challenge some different opinions.</p> <p>8 I am only going to allow comments, observations and                  9 contributions from those who sit around the horseshoe                  10 and the public gallery, questions as to clarification,                  11 but not questions that lead on to cross-examination,                  12 please.</p> <p>13 The programme will focus on matters relating to the                  14 healthcare work force, including access to children by                  15 those working in healthcare settings. By way of                  16 warning, this afternoon's topic will be the regulatory                  17 policy and legislative frameworks in which healthcare                  18 services operate, and the role that they play in                  19 effective prevention of child sexual abuse in healthcare                  20 settings. Tomorrow, we are going to look at issues                  21 arising out of culture and leadership, and a further                  22 couple of matters.</p> <p>23 At the end of each session, in the morning, before                  24 we have our breaks, we will take 10 or 15 minutes,                  25 depending on the time available and the desire to speak</p> <p style="text-align: center;">Page 17</p>	<p>1 go beyond this room. If that is the case, again, we                  2 will cut the video feed. If I consider anything                  3 sensitive to come up, I will pause and ask the chair to                  4 address it.</p> <p>5 As the chair has already mentioned, these                  6 discussions are only one aspect of the inquiry's work                  7 and the seminar sits within a much broader programme of                  8 work, including the Truth Project, our regional forum                  9 events, round table events and a significant amount of                  10 research which is being undertaken across a range of                  11 topics and across the inquiry's 13 investigations.</p> <p>12 You have been introduced to Hannah and Terri who are                  13 here to provide emotional support to anyone in the room.                  14 Please let yourselves be known to them if you wish to                  15 speak to them.</p> <p>16 As the chair has said, we are going to begin by                  17 playing a video, in which we will hear the views and                  18 experiences of people who have, as children, been abused                  19 in a healthcare setting.</p> <p>20 You will see them in silhouette. They are played by                  21 actors, but their words are their own. At this point,                  22 I am going to ask for the first video, please, to be                  23 played.</p> <p style="text-align: center;">(Video played)</p> <p>24 MS KARMY-JONES: Just to pause there for a moment and thank</p> <p style="text-align: center;">Page 19</p>
<p>1 from those in the public gallery to make contribution to                  2 the seminar. I will ask those who do wish to contribute                  3 to let us know by raising their hands and then Sue will                  4 take a microphone around.</p> <p>5 We will do our best to take as many comments as we                  6 can.</p> <p>7 It may be tempting to try to ask questions, but we                  8 have a busy agenda, so we will be keeping to that. As                  9 I have said, comments, observations, contributions only,                  10 please.</p> <p>11 Please remember that, because of their function in                  12 the wider inquiry, the panel are here to watch the                  13 discussion unfold, rather than to take an active part in                  14 it. People in the public gallery, you will not be seen                  15 on the video feed. If you want to share what you want                  16 to say with just those in this room, please just let us                  17 know. As you know, the video feed is taken out in the                  18 annex, where some people who come late may sit, or those                  19 who want to engage in tweeting or social media, they may                  20 sit out there. If you don't want what you say to go                  21 beyond this room, tell us, and we will cut the video                  22 feed.</p> <p>23 The delay in the video feed has already been                  24 mentioned. Sensitive matters may be dealt with in this.                  25 Some people may make reference to things that shouldn't</p> <p style="text-align: center;">Page 18</p>	<p>1 those who took part in making that video and for                  2 agreeing to share their views and experiences with us in                  3 this public forum.</p> <p>4 Moving on to the seminar, we sought views, as I have                  5 mentioned in advance, about a broad range of matters                  6 relating to the prevention of child sexual abuse. All                  7 of you around the horseshoe will have received a report                  8 summarising the themes that emerged from the responses                  9 that you and others provided. Hard copies are also                  10 available for those in the public gallery.</p> <p>11 A number of strong themes have emerged. In                  12 particular, you all highlighted the role of education                  13 and training of healthcare workers to equip them with                  14 the knowledge and skills to effectively prevent and                  15 respond to child sexual abuse in healthcare settings;                  16 the lack of focus on abuse that occurs within healthcare                  17 settings; and a need for greater consistency in the                  18 education and training provided. These were recurring                  19 themes. The safe recruitment of healthcare workers to                  20 prevent access to children by unsuitable people, that                  21 was also discussed extensively in the responses, many of                  22 which also identified various areas where respondents                  23 considered that the process for employment checks could                  24 be strengthened.</p> <p>25 A number of responses also focused on the</p> <p style="text-align: center;">Page 20</p>

<p>1 arrangements in place to prevent unsupervised or                  2 unauthorised access to children who are receiving                  3 healthcare and treatment and respondents focused on the                  4 chaperoning of workers and visitors and secure access to                  5 wards.                  6 So, in our discussions, can I ask you to take                  7 account of the following types of questions, and I will                  8 be asking questions, but these kind of bullet points:                  9 are things working as they currently stand; are there                  10 differences between the approaches in different areas of                  11 the country, and I look to those who are here from                  12 Wales; what isn't working; what's working well; what                  13 needs improvement; what is standing in the way of                  14 improvement; what's the solution, you know, what do you                  15 suggest should be done; why would you do it?                  16 Really, it comes down to this, doesn't it: what real                  17 difference will the solution that you suggest make to                  18 the protection of children?                  19 In terms of terminology, please bear in mind that                  20 when we talk about healthcare or staffworkers, we are                  21 talking a broad view of those terms to encompass health                  22 professionals such as doctors and nurses, but also other                  23 staff who are involved in the delivery of health                  24 services and even volunteers who work in healthcare                  25 settings. Healthcare settings, also, we are taking</p> <p style="text-align: center;">Page 21</p>	<p>1 any particular investigation, please. We don't want to                  2 go into particular detail about the Savile Inquiry or                  3 anything like that, please. It doesn't help us.                  4 The discussion is to help inform the inquiry's work.                  5 It is not the end of the process, it is part of                  6 the process. And there will be an opportunity outside                  7 the seminar to make points and raise evidence and to                  8 come back and add anything to what you have said.                  9 Finally, as a matter of courtesy, could I ask                  10 everyone, please, to speak through me, not start                  11 a public discussion, no matter how tempting it may be,                  12 because those watching will lose the thread.                  13 With all of that in mind, let's move on to topic 1:                  14 education and training.                  15 Discussion re Topic 1                  16 MS KARMY-JONES: What I am going to do is begin by asking                  17 the participants around the horseshoe to start by giving                  18 us their views on how well healthcare workers are                  19 educated and trained to detect and respond to child                  20 sexual abuse within the healthcare setting. Perhaps                  21 I can start out by looking to the Royal College of                  22 Paediatrics and Child Health.                  23 DR STEELE: Certainly. Alison Steele, Royal College of                  24 Paediatrics and Child Health, and a paediatrician.                  25 I certainly think that there have been improvements over</p> <p style="text-align: center;">Page 23</p>
<p>1 a broad view, so a hospital, a GP's practice or anywhere                  2 else where a child might receive healthcare and                  3 treatment.                  4 We are going to move on to the questions soon, but                  5 a few points. Learning from experience is important,                  6 but we would like to avoid entering into detailed                  7 discussions about the nature of current policies and                  8 processes, and I will try to steer us away if we start                  9 going into that sort of territory.                  10 Many of you around the table -- indeed, all of                  11 you -- are experienced in working in the health system,                  12 but others observing may not be, including those who                  13 will be dipping in and out of the live feed and those                  14 who may later come to watch the video footage of this on                  15 the IICSA website. So please avoid acronyms and jargon                  16 as much as possible, and please also do introduce                  17 yourself. The video won't always pick up your name and                  18 where you are from, and it would help people watching to                  19 know that before you answer a question.                  20 The intention of the discussion, as I have said, is                  21 not to put anyone on the spot or force them to justify                  22 a position that they or the organisation have taken. We                  23 may press people a little and ask a little around where                  24 there are disagreements, but this isn't an inquisitorial                  25 process. So avoid -- another point is, avoid going into</p> <p style="text-align: center;">Page 22</p>	<p>1 the years. Certainly I can remember being at medical                  2 school and having no training at all around safeguarding                  3 children. I think even in my early years as                  4 a paediatrician, having no training, and actually                  5 training was much more experiential than any structured                  6 form. You learnt often by being involved and seeing                  7 children where there were such concerns.                  8 We now have a structured training, but it is                  9 advisory, so, as you're aware, there's the                  10 intercollegiate document between various Royal Colleges                  11 that sets out what level of training healthcare                  12 professionals should have, depending on their                  13 involvement with looking after children. It sets out                  14 knowledge and it sets out competencies. So that is                  15 a vast improvement to previously.                  16 However, I would say that that document is advisory.                  17 It is not statutory. I'm aware that inspectorates do                  18 look at that and certainly CCGs and commissioners look                  19 at the levels of training. However, I think that one                  20 can train to that document, but actually we need to see                  21 how we embed that training. So people can go to                  22 a training session and then leave it, and how do we know                  23 that they are actually putting what they have been                  24 trained about into practice? I think that is a very,                  25 very difficult issue, about how you evaluate training.</p> <p style="text-align: center;">Page 24</p>

<p>1 I also think that there are things in addition to  2 training that are reinforcing that we need to be firmer  3 about, particularly around clinical supervision in  4 healthcare settings, whether that be GP practices,  5 wards, emergency departments. I sometimes think that,  6 although -- and it is very much more embedded in nursing  7 practice than I would say in medical practice, although  8 the Royal College of Paediatricians and Child Health  9 does have a document around peer supervision, around  10 looking at particular cases, but I don't think it should  11 be just in supervision around safeguarding. I think if  12 there is a generally robust clinical supervision service  13 within a healthcare organisation, then those sort of  14 issues are going to come up and people are going to be  15 able to discuss them. So I think that, actually, the  16 supervision side of it and the peer review/support side  17 of it are very important.</p> <p>18 Obviously I also think -- I know this sort of  19 crosses into another workshop, but just the general  20 culture within organisations, allowing people to  21 actually put into practice what they have been trained  22 about or what they have been supervised about, allowing  23 them to act on any discomfort, to have professional  24 curiosity, and to think the unthinkable.</p> <p>25 MS KARMY-JONES: Thank you very much. What about Vimal? Do</p> <p style="text-align: center;">Page 25</p>	<p>1 authorities each have their own thresholds for  2 acceptance of referral. As GPs, we are expected to  3 maintain a consistent standard of clinical practice  4 regardless of which area of the country in which we  5 practise, and this is difficult in relation to working  6 with local authority thresholds. So in some parts of  7 the country, a referral of a child will be accepted,  8 whereas in another part of the country, it might be  9 refused. This is something we really find very  10 difficult. We are holding in some parts of  11 the country -- GPs are holding a number of troubled  12 families in their practices with very little support  13 from other agencies.</p> <p>14 MS KARMY-JONES: Thank you. What about Helen? Do you have  15 anything to add to that in respect of the nursing?</p> <p>16 MS CHRISTODOULIDES: I honestly don't know what's provided  17 by way of education training to undergraduate nursing  18 training these days. I'm sure colleagues around the  19 table might.</p> <p>20 I do know that we have implemented the  21 intercollegiate document and safeguarding training at  22 all levels recently into our organisation in a formal  23 way and that largely is being well received. I would  24 echo what colleagues have said about, generally,  25 education in healthcare improvement, it's a weak form of</p> <p style="text-align: center;">Page 27</p>
<p>1 you have any views on this?</p> <p>2 DR TIWARI: I would reinforce much of what Alison said about  3 the intercollegiate guidance, which is not statutory,  4 but which is followed to a certain extent. I think we  5 need to guard against training becoming just a tick-box  6 exercise. What we have tried to do at the college is to  7 bring safeguarding training into the context of  8 a 10-minute consultation, and to bring it away from  9 a social care perspective to a primary care perspective.</p> <p>10 The difficulties we face are that there is  11 underprovision of education across the country, so we  12 have an ally in the Care Quality Commission who have set  13 out their requirements for safeguarding and general  14 practice. They are supporters of our Safeguarding  15 Toolkit, and also the way in which GPs should be  16 educated in safeguarding.</p> <p>17 What we have found is that the standard of CQC's --  18 Care Quality Commission's -- assessment, is variable  19 across the country.</p> <p>20 What they have found is that in areas of the country  21 where there is a named safeguarding GP, there is a very  22 appreciable difference in the way practices approach  23 safeguarding. So that's an area of good practice which  24 could be adopted across the country.</p> <p>25 One of the barriers to consistency is that local</p> <p style="text-align: center;">Page 26</p>	<p>1 improvement, and the comments about culture and  2 leadership are so intertwined with the education and  3 training and the ability then to act as a healthcare  4 professional, it's so interlinked, I -- that's what  5 I was thinking about when you were saying it.</p> <p>6 But one of the things in the prereading in the  7 document was about not making it a tick-box exercise,  8 trying to be more innovative. In the run-up to our  9 safeguarding week in our city in our organisation, we  10 are doing a raft of things around safeguarding:  11 introducing them into Schwartz Rounds, which are part of  12 our health and well-being agenda; the coroner is coming  13 to talk to people; we are doing lunchtime sessions. We  14 are slowly and innovatively entering the psyche, I hope,  15 of lots and lots of our staff in different ways, as well  16 as making sure people sit down and do e-learning for two  17 hours on safeguarding training, and I am proud of that  18 and I think it is useful and will contribute.</p> <p>19 MS KARMY-JONES: Thank you. Clarisser, what about you? Do  20 you have something to add to that?</p> <p>21 MS CUPID: One of the things that we have to recognise is  22 that safeguarding is not just a single agency. We have  23 to work together. One of the things to add to  24 everything that everyone else has said is that  25 multi-agency training is key. It is about understanding</p> <p style="text-align: center;">Page 28</p>

<p>1 each other's roles and responsibilities which in health                  2 we all have our own single agency framework that we                  3 follow. We have our induction training and then the                  4 intercollegiate document also highlights or sets out                  5 different levels of training for each role and                  6 responsibility within health. But multi-agency is also                  7 key because that's where you have early identification,                  8 where you are working together with colleagues from                  9 other areas, where there's social care, education, but                  10 other services as well, and identifying concerns quite                  11 early on.</p> <p>12 It is also about setting the standard so that you                  13 create a culture, a culture where people feel confident                  14 enough that, if they do have a safeguarding concern,                  15 they can actually share that, and it is also not just                  16 about the training but having the policies and                  17 procedures that back that up, that staff feel confident                  18 enough to raise a concern. So education alongside                  19 supervision and everything else is what we actually need                  20 to develop a bit further.</p> <p>21 MS KARMY-JONES: Thank you. Just bringing it back to abuse                  22 within the healthcare setting, can I ask you all just to                  23 focus on something that's come back to us, which is that                  24 there is training and there's education, but often                  25 there's a lack of focus on the abuse that is carried out</p> <p style="text-align: center;">Page 29</p>	<p>1 them in safeguarding according to the collegiate                  2 document, but we segregate that from compassionate                  3 care-type models as something else around how you                  4 technically do the job, et cetera, in certain cases.</p> <p>5 So I think that can be a challenge.</p> <p>6 I think, Helen, you touched on the issue of what                  7 happens preregistration within organisations. Again,                  8 I don't know, but I think it is very hit and miss.</p> <p>9 There were some a few years ago, some very good                  10 interdisciplinary training, because, whilst it is right                  11 that the issues of multi-agency are really important,                  12 many times in serious case reviews what we see is that                  13 interdisciplinary workings within the health community                  14 remain a challenge, communicating with each other and                  15 training around those issues. I think it is really                  16 important as well.</p> <p>17 But it has to start preregistration: medical school,                  18 those issues. And interdisciplinary training in the                  19 most -- I think it was Nottingham University, in the                  20 most creative situations, we have seen some very good                  21 safeguarding work done, so that the staff come into                  22 their profession already tuned into the idea of                  23 multi-agency working in safeguarding children.</p> <p>24 MS KARMY-JONES: So it sounds like you are drawing                  25 a distinction between education and onsite training.</p> <p style="text-align: center;">Page 31</p>
<p>1 by healthcare workers themselves. Is that something                  2 that resonates with you? Helen?</p> <p>3 MS CHRISTODOULIDES: I'm desperately thinking, having just                  4 done my safeguarding training, how much of a focus did                  5 we put on others. I think you might be right. I think                  6 that might be accurate. I'm thinking about our                  7 chaperoning policy and the views that staff have about                  8 the purpose of that policy, and some people have said to                  9 me, "It is there to protect me as the healthcare                  10 professional", and some people believe it is solely                  11 there to protect the patient, and of course it is both.</p> <p>12 I think that there's a lack of understanding in general                  13 and focus on harm that could be caused to patients in                  14 hospital by staff. So yes, probably.</p> <p>15 MS KARMY-JONES: Anyone else? Ray?</p> <p>16 MR McMORROW: I think -- I can't comment for any individual                  17 NHS organisation, but I think what I would say is that                  18 there is a separation -- there's a lot of drives around                  19 compassionate care, and many of them have come around                  20 abuse issues with adults, often, disabilities,                  21 et cetera, that have led to a drive. That drive isn't                  22 separate from safeguarding when we are talking about                  23 adult safeguarding, but to me, it feels like in                  24 children's safeguarding those things are separated so                  25 that, when we train people in safeguarding, we train</p> <p style="text-align: center;">Page 30</p>	<p>1 MR McMORROW: Yes.</p> <p>2 MS KARMY-JONES: Can I just ask if that is a distinction                  3 that others feel is an appropriate one to make?</p> <p>4 DR TIWARI: Yes. I would totally support that. Because                  5 over the years, we have lost sufficient undergraduate                  6 training in medicine in child health, so child                  7 safeguarding to me is very much an integral part of                  8 child health provision. When I was a medical student,                  9 child health was given equal status to subjects like                  10 medicine and surgery. Whereas now, in certain medical                  11 schools, child health is just barely addressed. We have                  12 had trainees coming into general practice who have never                  13 been taught to examine a baby, for example, so there is                  14 a huge education gap out there for some new doctors                  15 entering the profession.</p> <p>16 I would totally support Ray's point about somehow                  17 trying to ensure that child safeguarding is embedded at                  18 an undergraduate level. I am echoing Lord Laming's                  19 recommendations from all of those years ago. It hasn't                  20 happened yet.</p> <p>21 MS KARMY-JONES: Can I then turn to Giles. Can you add                  22 anything to this?</p> <p>23 MR DENHAM: Yes, Giles Denham. I think I can.</p> <p>24 MS KARMY-JONES: You are Health Education England?</p> <p>25 MR DENHAM: Yes, we are the arm's-length body, the statutory</p> <p style="text-align: center;">Page 32</p>

<p>1 body, responsible for national education and training.                  2 So we look after the platform, the framework, that is                  3 provided through what's called e-Learning for Health,                  4 which is where health professionals can access the                  5 framework that came out of the intercollegiate document.                  6 I think -- I do try to come back to your point about                  7 people being aware of the risks within healthcare                  8 settings as being the real focus. I think that is,                  9 speaking as someone who used to run a hospital many                  10 years ago, a quite uncomfortable thing for people to                  11 come to terms with across all professions. I am not so                  12 sure whether that will fit comfortably into an                  13 undergraduate curriculum. I do think for organisations                  14 it almost certainly will, and I think probably, although                  15 I'm not authorised to say it, it would be worth somebody                  16 looking again at the intercollegiate document to see                  17 whether the emphases are sufficiently strong in that                  18 area. I think it is great on safeguarding generally,                  19 but this is a slightly different area and one we                  20 probably do need to think further about.                  21 Can I make one other point while I am talking?                  22 There has been a bit of debate about the advantages or                  23 disadvantages of having these frameworks and having                  24 mandatory training and whether people do turn it into                  25 a tick-box exercise. I think that is very wise for</p> <p style="text-align: center;">Page 33</p>	<p>1 are worried about?" Because these things aren't always                  2 blatant. They are not usually blatant. If it is                  3 a blatant case, then that is almost easier to deal with.                  4 It's the small things, the interactions, the things that                  5 you might observe that give you a hint that actually                  6 more is going on. So I think that is a very difficult                  7 thing and I think that is much more going -- you are                  8 going to be able to do that much more in face-to-face                  9 training than you are in any sort of e-learning package.                  10 The second thing was around chaperone policy.                  11 I think people have chaperone policies and maybe staff                  12 don't always understand, you know, why, and I agree that                  13 it -- the prime purpose is for the safety of                  14 the patient, but it also does safeguard professionals as                  15 well. But people need to be trained about how to                  16 chaperone, because, actually, there's usually a power                  17 differential between the person who is doing an                  18 examination and that person that's supposed to be                  19 chaperoning. So you need to ensure that they would be                  20 able to question, to challenge, to intervene                  21 appropriately.                  22 MS KARMY-JONES: I will come back to the tick-boxing, but                  23 obviously there is potential for a disparity and a lack                  24 of consistency between different organisations. How do                  25 we deal with that? Have we got any views on that? Or</p> <p style="text-align: center;">Page 35</p>
<p>1 people to be aware of. Equally, if you are in an                  2 organisation which doesn't pay any attention to                  3 mandatory training, that might itself say some things                  4 about the organisation's attitude to training in general                  5 and the importance of it. So it is a "both and" for me,                  6 not just an "either or".                  7 MS KARMY-JONES: I am going to come back to the tick-box in                  8 a minute. Alison, from the Royal College of                  9 Paediatricians, can you add something?                  10 DR STEELE: Yes, I wanted to come back to your question                  11 about, do we train enough about abuse potentially by                  12 healthcare professionals, and I think the answer is, no,                  13 we don't. The last intercollegiate document was written                  14 in 2014, so it would have been prepared in 2012/13.                  15 Before a lot of the issues have come up, particularly                  16 around chaperoning. So I think that when we rewrite                  17 that document, we need to take into account what we have                  18 learnt more recently.                  19 I think it is a very difficult thing to train on.                  20 It is incredibly difficult to train in e-learning                  21 because what you are asking people to do is to view                  22 their colleagues potentially in a different light,                  23 people that they socialise with. So I think we need to                  24 be saying to people, "You know, if you have a gut                  25 feeling that something isn't right, what is it that you</p> <p style="text-align: center;">Page 34</p>	<p>1 is that too wide and too big a question? Ray, I can see                  2 you making a gesture.                  3 MR McMORROW: Could you ask it again?                  4 MS KARMY-JONES: Disparity and the lack of consistency. It                  5 is something that has been mentioned around the table.                  6 Is there any way we can deal with disparity? Is it                  7 recognised that there is disparity?                  8 MS BEAUMONT-WOOD: Sorry, I am trying to come in.                  9 MS KARMY-JONES: Sorry, Rhiannon. I was going to come to                  10 you.                  11 MS BEAUMONT-WOOD: That's fine. On that particular point,                  12 within Wales -- maybe it is easier because of                  13 geography -- we do have all-Wales safeguarding                  14 procedures and it is multi-agency. Obviously it is                  15 there to try to deal with the variation that people have                  16 talked about. I'm not saying it is perfect. Certainly                  17 in my experience, similar to somebody that mentioned                  18 over there, when working with 22 local authorities -- it                  19 was over here, actually, it was yourself, wasn't it --                  20 the variation in terms of thresholds. So there is                  21 something about getting a more consistent approach and                  22 understanding about thresholds.                  23 But I think it is possible to reduce the variation                  24 by having a multi-agency set of procedures that can span                  25 as wide a geography as possible. As I said, probably</p> <p style="text-align: center;">Page 36</p>

<p>1 slightly easier in the context of Wales.                  2 Just whilst I'm on my feet, so to speak, I think the                  3 other thing is about, where we have a number of topics,                  4 and I think it speaks to Ray's point slightly, so in the                  5 safeguarding agenda now it has been exponential in terms                  6 of what topics sit under it, so if we think about the                  7 prevent strategy in domestic abuse, safeguarding                  8 children, safeguarding adults, and actually, while we                  9 don't want to diminish anything around making sure we                  10 equip people to be able to respond and prevent things,                  11 I think we need to take the opportunity to look at this                  12 in the round, because lots of the things we need people                  13 to do are actually quite similar. I think by trying to                  14 keep things siloed, it works against organisations being                  15 able to grapple with this. I mean, at the end of                  16 the day, training is the one thing that every                  17 organisation will be challenged by, frontline staff                  18 being released to do their mandatory training. Whilst                  19 everybody would recognise how important it is, the                  20 challenge is it means somebody is not doing something                  21 else. We all know about shortages of nursing and the                  22 midwives and doctors. The challenges of recruitment                  23 across the UK, globally. We need to think about how we                  24 do this and make the best use of our time to ensure that                  25 we are equipping. I just wanted to say that.</p> <p style="text-align: center;">Page 37</p>	<p>1 need to be at, the horrors of child sexual abuse often,                  2 to many professionals, and many of us have been involved                  3 in the work over the years, have been stories and                  4 horrors that we wouldn't have imagined, we wouldn't have                  5 thought, and sometimes I think the only way we can truly                  6 get more effective awareness and training is through                  7 that multi-agency work. That's why what we have tried                  8 to do in the Welsh context is build up. So we have now                  9 got regional safeguarding children boards that cover                  10 a number of authority areas, really getting into that                  11 thorny issue, trying to deal with inconsistencies in                  12 practice, and alongside that Welsh ministers have                  13 created a national independent safeguarding board with                  14 a team of experts who are then able to advise us working                  15 directly with the regional board. So bringing learning                  16 together, enabling us then to begin to tackle together                  17 some of the big challenges that we all clearly face.                  18 MS KARMY-JONES: Thank you. Simon?                  19 MR DEAN: Not at this stage, thank you.                  20 MS KARMY-JONES: How does that compare with what takes place                  21 here, then?                  22 DR TIWARI: Could I just mention a very exciting initiative                  23 which has come from the European Union, which is                  24 a series of multi-agency training modules produced and                  25 validated across eight countries. These are</p> <p style="text-align: center;">Page 39</p>
<p>1 MS KARMY-JONES: Thank you. I wonder if, Simon and Albert,                  2 you have anything you want to add to that from the Welsh                  3 perspective?                  4 MR HEANEY: Thank you very much. There are a few things                  5 I would like to add. The first point I would like to                  6 make, I think we have got to raise more profile around                  7 the voice of the child, the young person, directly. We                  8 are talking today about training and education for                  9 staff, but the heart of that has to be engagement in the                  10 way we talk and communicate. How do we see the signs of                  11 safety? How do we get to communicate? I think that is                  12 one of the things just to profile a bit more in the                  13 conversation that's taking place.                  14 In terms of training, Wales has gone down the route                  15 of mandatory training. It's taken that. It is easier                  16 for us, in a sense, because of our size and our scale,                  17 although we do find complexities sometimes having                  18 22 authorities. We have tried to reduce that complexity                  19 in terms of the way we have approached it.                  20 In terms of that mandatory training, Public Health                  21 Wales and others make sure that the standards are                  22 adhered to and it is wedded into some of the culture and                  23 practice around, you know, management and supervision                  24 and accountability.                  25 But to really take it to the level, I think, that we</p> <p style="text-align: center;">Page 38</p>	<p>1 multi-agency training modules, and centred very much on                  2 the UN Convention on the Rights of the Child. So the                  3 child is at the centre. The modules are based on the                  4 assessment triangle, which would be familiar to many                  5 people.                  6 I would urge -- if we are going to go forward and                  7 try to find a consistent means of educating all                  8 professionals -- that we start with that as                  9 a foundation. Because it is an excellent piece of work.                  10 MS KARMY-JONES: So in terms of consistency, how do you --                  11 you have made a suggestion, Vimal, on that. Is there                  12 any lack of consistency between different organisations                  13 and also the way training is offered to those who may                  14 come into the health service, say, from abroad, from                  15 a different training base? One of the things I think                  16 you said earlier was that it should be embedded into the                  17 undergraduate programme. Well, if undergraduate                  18 programmes haven't been undertaken here, how should that                  19 be dealt with? Anthony, do you have any views on this?                  20 MR OMO: I do, thanks. So we set the education standards                  21 for the UK doctors and, for those coming from abroad,                  22 they are required to meet similar standards. So we                  23 check, upon registration, a number of things around                  24 education and training and that they are then fit to                  25 practice. For me, and it echoes what has been said</p> <p style="text-align: center;">Page 40</p>

<p>1 around the room, education only goes so far. It is                  2 a necessary component but it is not sufficient. We do                  3 work with employers on this, but the employer, where the                  4 doctor is now going to actually practise, has a role to                  5 play in making sure that the doctor is up to speed with                  6 the local guidance and training. We issue tonnes of                  7 guidance across for all doctors, but it is the                  8 practicability of it, how it works in practice. So for                  9 us, we do the initial checks, but it is a high-level                  10 check. What the doctor is actually going to do needs                  11 the employer to keep an eye on and make sure that they                  12 follow the training and processes there.                  13 MS KARMY-JONES: To some extent, that harks back to the                  14 tick-boxing, the tick-box exercise.                  15 MR OMO: Indeed. I think that's -- again, echoing thoughts                  16 and comments around the room, I think it is bringing                  17 everything together. So the education is necessary, it                  18 absolutely is, and some consistency, and we make sure we                  19 set out for undergraduates and post graduates that, so,                  20 if you train in this country, it is consistent and                  21 safeguarding is an absolute part of that, but that only                  22 goes so far because doctors practise in all sorts of                  23 settings and they don't work alone, and that's where the                  24 multi-agency comes in. And we don't regulate others                  25 outside the doctor. So I think working with employers,</p> <p style="text-align: center;">Page 41</p>	<p>1 MS KARMY-JONES: So on that -- yes, Alison?                  2 DR STEELE: Sorry, Alison, Royal College of Paediatricians.                  3 Yes, the other thing I think is training passports,                  4 because one of the things -- it is mentioned in the                  5 documentation, but one of the, I suppose, higher-risk                  6 areas for organisations is either honorary -- Trust                  7 staff on honorary contracts who work mainly elsewhere or                  8 agency staff. Then the essential nature of having some                  9 sort of a training passport so that you know that people                  10 are up to date with their training immediately they come                  11 into your organisation.                  12 The problem with lack of standardisation is, if we                  13 want to implement a passport, how do we trust that they                  14 have been trained appropriately within another                  15 organisation? So I don't know how we tackle this, but                  16 it may be that there needs to be -- I tend to be                  17 somewhat against increasing prescription, because it                  18 goes against, you know, looking at developing sort of                  19 professional competencies and curiosity, but maybe we do                  20 need to have something in terms of baseline standards so                  21 we can actually implement the passport system that would                  22 actually help with the higher-risk areas of honorary                  23 contracts and agency staff within healthcare                  24 organisations.                  25 MS KARMY-JONES: Thank you. I am going to come back to</p> <p style="text-align: center;">Page 43</p>
<p>1 the culture, it is all quite mixed in. To make sure                  2 people know what rights are, what they are doing, why                  3 they are doing it and how they're doing it. I think                  4 a very important point made about the patient, at the                  5 centre of it all, an informed patient, so they can raise                  6 things, and you create the environment where they can                  7 raise their concerns, be it in a hospital setting or                  8 elsewhere. I think that is quite important. That's                  9 where I think there is perhaps a gap, because there                  10 isn't a patient group per se, in the same way there are                  11 colleges and others for doctors, that you can get at to                  12 get that education out there.                  13 MS KARMY-JONES: How do we fill the gap?                  14 MR OMO: I don't have the solution right now. I think we                  15 continue to work with others, so we work with other                  16 regulators, we work with our local safeguarding and                  17 local authorities, but as you mentioned, if you go to                  18 different ones, you get different responses, and maybe                  19 that's something to look at. We have lots of                  20 memorandums of understanding where we share information,                  21 we refer things to the Disclosure and Barring Service                  22 when we need to do so. So I think we are plugged into                  23 a whole raft of places and organisations, but they are                  24 not all working, if you like, in the same way and at the                  25 same pace. Maybe there is something around that.</p> <p style="text-align: center;">Page 42</p>	<p>1 training passports. I think it was one of                  2 the suggestions that came to us in the documentation.                  3 But taking that point of a kind of baseline and taking                  4 Anthony's point, who is, or which organisation is, best                  5 placed to make improvements or to take improvements                  6 forward? Because it is all very well for us to                  7 recognise that, yes, there are levels of communication,                  8 but there is no overarching overview pulling it all                  9 together to ensure that everyone is working in the same                  10 way. Who is best placed? Alison?                  11 DR STEELE: I think this is where commissioning plays                  12 a really important role, and I know that is going to be                  13 probably discussed more this afternoon/tomorrow. But                  14 I think that commissioners are in a position to be able                  15 to demand certain standards, as are inspectorates. So                  16 I think the role of commissioners and inspectorates in                  17 determining standards and also what might go into                  18 a training passport might be an important one.                  19 MS KARMY-JONES: Thank you. What about Sue, on behalf of                  20 NHS England? You have an overview, could you make some                  21 observations about this?                  22 MS WARBURTON: Absolutely. I agree. I think training                  23 passports -- we are seeing it already in the social care                  24 setting, and helping people move across the system                  25 effectively. As we see more agency staff, more locum</p> <p style="text-align: center;">Page 44</p>

<p>1 working, more members from other countries coming to 2 work with us, these are the things that will help us 3 maintain the standard that we are talking about. 4 You have mentioned also about a range of topics this 5 morning, but I would like to particularly pick up around 6 some of the recruitment elements and some of the work 7 that actually is done within organisations when we do 8 bring foreign workers into the health sector. There are 9 extensive programmes of development for those workers 10 when they come and they are nurtured through the system, 11 and I suppose you will perhaps recognise that, when you 12 bring people in, you put them through development, they 13 have safeguarding training of various sorts. 14 What I think we perhaps do need to do is pick up 15 more of the model that we are talking about in Wales 16 where we are looking more holistically at safeguarding 17 now with those key messages, because we keep segmenting 18 safeguarding and, actually, we need to think more 19 holistically, because we have got -- we are training 20 people in adults but those adults are often engaged with 21 children in care homes, et cetera. 22 MS KARMY-JONES: Sue, who do you say would be best placed to 23 put this into action? 24 MS WARBURTON: I think it's a range of people. I think 25 I would agree that the regulators have a role to play.</p> <p style="text-align: center;">Page 45</p>	<p>1 expectation would be the employer, who is ensuring that 2 their organisation and all the staff that work for it 3 are appropriately trained, supervised and supported; 4 supported by frameworks and others, including by 5 government and with the regulatory input, which, again, 6 is different in the English and the Welsh system. But 7 I personally think the primary responsibility sits with 8 the employer. 9 MS BEAUMONT-WOOD: Can I add to that? I agree, but I think, 10 in addition, it is -- it can't be one single agency. 11 I think it is kind of what Albert referred to earlier: 12 regional safeguarding boards hold the multi-agency 13 representatives to account. They have to submit reports 14 to demonstrate how they are complying. The national 15 safeguarding board now can provide that oversight and 16 scrutiny. Health Inspectorate Wales will look at health 17 and care standards, which is our equivalent of CQC. And 18 within organisations, of course, they also have to 19 assure their boards. So I think it is very difficult to 20 say it would be one. I think there are many levers. 21 And I think any recommendations that come out need to 22 think about the difference in terms of the NHS context, 23 because they are quite different in England and Wales, 24 so kind of one or two bullet points may actually, you 25 know, not have the outcome that you would be looking for</p> <p style="text-align: center;">Page 47</p>
<p>1 I think NMC have a role to play in actually making sure 2 that when we are registered, we do have those 3 revalidations and things in place. When we revalidate, 4 we don't have to actually say that we are up to date 5 with safeguarding. Yet, it's the core principle of 6 everything that we do. 7 MS KARMY-JONES: What are the levers and incentives that 8 might be brought to bear on this? 9 MS WARBURTON: I think a range of levers. We use our NHS 10 standard contract to good effect. I have been 11 a commissioner previously and put quite rigorous 12 standards in place in a previous role around 13 safeguarding, which allows us then to challenge very 14 effectively our providers on the detail, and I think it 15 is -- that is where it needs to be, it sits within your 16 contracts, it sits within those schedules. So the NHS 17 contract is a start, but it is about the schedules and 18 I have seen some very effective safeguarding schedules 19 within contracts. 20 MS KARMY-JONES: Rhiannon -- Simon? 21 MR DEAN: Perhaps just to draw a difference from the Welsh 22 to the English context. My answer to, "Who is 23 responsible?", is the employer. We don't have 24 separation between commissioners and providers in the 25 Welsh system. We have integrated bodies. So my</p> <p style="text-align: center;">Page 46</p>	<p>1 as a panel. 2 MS KARMY-JONES: Thank you. Ray, you had something, and 3 then I will come to you, Christine. 4 MR McMORROW: Yes, just on a similar theme, the Care Quality 5 Commission I think have moved forward in the past 6 18 months, bringing specialist advisers on safeguarding 7 into practice, into inspections, et cetera. I think 8 that's a really positive move, to actually engage people 9 who will in some ways know what they are looking at when 10 they are going in. Often former designates, et cetera, 11 going in and actually looking at that. I think that is 12 a positive move because it is about the inspectorates 13 knowing what it is they are looking for. I think that 14 issue about mandatory or statutory, I think they are 15 words, as far as I'm concerned. I think it is actually 16 about how you enforce and ensure there is competency in 17 the system that matters most, and I think CQC have taken 18 some good steps, although I recognise the resources for 19 them are quite tight as well. 20 MS KARMY-JONES: I just point out we do have someone from 21 the CQC, the Care Quality Commission, coming a little 22 later this afternoon, I think. So we may be able to 23 turn and ask them for their views a little later. Thank 24 you. Christine? 25 MS BRAITHWAITE: Thank you. I just didn't want to lose</p> <p style="text-align: center;">Page 48</p>

<p>1 sight of the concept -- Christine Braithwaite,                  2 Professional Standards Authority, apologies -- of                  3 the important point I think Alison made early on in the                  4 discussion, which is around the importance of developing                  5 professional curiosity. I think there is a role for                  6 educational institutions in collaboration with                  7 regulators in starting that training and education                  8 during the undergraduate time and continuing all the way                  9 through. It is a lesson really from the aviation                  10 industry also in terms of developing constructive                  11 mistrust. It is that permission for one group to be                  12 able to challenge the behaviour of another group. That                  13 requires practice as well as imparting information. So                  14 there is an important part in terms of giving                  15 information, making sure that information is consistent,                  16 but also then in practising those behaviours so that                  17 they become ingrained, and that, once students move into                  18 the workplace, they can continue to practise them when                  19 they actually encounter those real-life situations where                  20 they need to act.                  21 MS KARMY-JONES: Thank you. A final observation, perhaps,                  22 from Lorna, and then we will move to the public gallery.                  23 DR PRICE: Thank you. Lorna Price, designated doctor                  24 national safeguarding team in Wales. Just to say that,                  25 in Wales, doctors have an online medical appraisal and</p> <p style="text-align: center;">Page 49</p>	<p>1 MR DENHAM: Very quickly. I would agree with Rhiannon that                  2 non-executive boards are a powerful tool within the                  3 health organisation. The other thing to say is we have                  4 talked a lot about secondary care organisations.                  5 Primary care is always quite different because you don't                  6 have the standard contracts, so you are possibly more                  7 reliant on regulators, but, again, they are spread                  8 thinly.                  9 MS KARMY-JONES: I am going to open it up now and see if                  10 there is anyone within the public gallery who would like                  11 to say something. I see Mr O'Mara has his hand up. If                  12 Sue would like to get the mic.                  13 Observations from the public gallery                  14 MR O'MARA: Good morning. Nigel O'Mara from East Midlands                  15 Survivors. Core participant and survivor. I have been                  16 involved in running workshops for Care Commissioning                  17 Groups for GPs in first contact and appropriate referral                  18 for the last couple of years, and also working with                  19 multi-agency groups in my area to look at the issues                  20 around training for victims of sexual abuse and people                  21 who are coming into contact with them.                  22 What we do see greatly is this disparity. There is                  23 no level playing field. We find that some areas don't                  24 send the most appropriate person to those multi-agency                  25 meetings, somebody who can't make the right -- the</p> <p style="text-align: center;">Page 51</p>
<p>1 revalidation system in which they are required to state                  2 what level of safeguarding training they have undertaken                  3 and how recently. So that should be a discussion that's                  4 had at appraisal with their appraiser and would inform                  5 the responsible officer when they are looking at                  6 revalidation, and so on.                  7 The other thing about standards, I suppose, and                  8 getting consistency across the piece, Rhiannon mentioned                  9 briefly the NHS Wales safeguarding network, which is                  10 a collaboration between senior nursing staff responsible                  11 for safety and quality and safeguarding from all the                  12 health boards and NHS Trusts. Along with the national                  13 safeguarding team, we also have representation there                  14 from Welsh Government. It is a forum, really, for                  15 sharing good practice, but also there is a bit of sort                  16 of challenging of one another and nobody wants to be                  17 seen as practising, you know, a lesser level than                  18 others. So it does work very well and has led to                  19 development of tools and audits. It comes to mind                  20 things like -- sorry, senior moment. My mind has gone                  21 blank. Risk assessment tool for children who are cared                  22 for in adult areas within the health service, where they                  23 would be particularly vulnerable. So those kind of                  24 innovations, really.                  25 MS KARMY-JONES: Giles, just one last point.</p> <p style="text-align: center;">Page 50</p>	<p>1 decisions at the time, and then, when it gets passed                  2 back, no further action is taken.                  3 So it is all very well having a multi-agency                  4 attitude and approach to it, but unless you have got the                  5 right people in those multi-agency meetings, it's never                  6 going to actually produce an equal and open training                  7 module.                  8 I am also working with the University of Nottingham                  9 to prepare an undergraduate workshop for them for next                  10 year. I'm finding that, again, there is a disparity.                  11 Some parts, they want to use it in some parts, they                  12 don't want to use it in others. I think this sort of                  13 safeguarding has to be seen as something that needs to                  14 be done generically across the whole system. Thank you.                  15 MS KARMY-JONES: Thank you very much. Is there anyone else                  16 in the public gallery who has something they would like                  17 to contribute?                  18 MEMBER OF THE PUBLIC: I would just like to make a comment                  19 on whether things should -- you know, this is a seminar                  20 to find out what to do to stop it happening. Now, the                  21 last incident, the last seminar, we had a professor                  22 there turn around -- and when I've been to it, I took it                  23 out the context of what he said. But I have it on my                  24 phone here as to what he said. And that is, don't take                  25 a note and don't record when somebody is giving you</p> <p style="text-align: center;">Page 52</p>

1 a disclosure. Can we clarify that? That in these, what  
 2 you call -- well, what I called a log when I was doing  
 3 youth work, I had a log of all the things I'd done, and  
 4 that is the priority. I know doctors and nurses, if  
 5 I go to them -- or a child goes to them and says  
 6 something, it's got to be reported immediately. As  
 7 a youth worker, when one disclosure was given to me,  
 8 I immediately forwarded it, which you have got to do.  
 9 When you have a professor telling us, "Don't make a note  
 10 of something", so can we get that clarified, as to  
 11 whether they should make notes or not, because that is  
 12 one of the greatest preventions?  
 13 MS KARMY-JONES: That's one of the things which came out of  
 14 the last seminar, which was to do with record keeping  
 15 and whether records were kept accurately and stored for  
 16 a lengthy period of time.  
 17 MEMBER OF THE PUBLIC: And the example I give with myself,  
 18 as I said, was because I have got no record of it being  
 19 anywhere, I remember that in 1970, it should be on file  
 20 in the courts, but criminal injuries have denied people  
 21 compensation because of it, because they have not been  
 22 recorded. So, on that, the log should say, make sure  
 23 they record everything.  
 24 MS KARMY-JONES: Thank you very much. Anyone else before we  
 25 break? And those comments we will consider over the

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1 break.  
 2 I don't know, madam chair, if that will be an  
 3 appropriate moment?  
 4 THE CHAIR: We will take a 15-minute break now.  
 5 (11.30 am)  
 6 (A short break)  
 7 (11.45 am)  
 8 Discussion re Topic 1 (continued)  
 9 MS KARMY-JONES: We have talked a bit about multi-agency  
 10 approaches and the fact that agencies need to work  
 11 together. I want to move on a little bit from that into  
 12 some of the practical issues, such as what is the  
 13 prevalence of child sexual abuse? Do we know what the  
 14 prevalence is around child sexual abuse in a healthcare  
 15 setting?  
 16 One of the things we do know is that, as a matter of  
 17 commonsense, there is a greater opportunity,  
 18 potentially, for abuse in a healthcare setting, given  
 19 the intimate nature of the relationship between  
 20 a patient and, say, a doctor, a nurse or others working  
 21 in a hospital setting, for example. So there is  
 22 a practical reality to that, and we have to be conscious  
 23 of the fact that what training can do -- you know, when  
 24 you are talking about globalising training and making  
 25 things consistent, what you can do in relation to

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1 a child in one setting is going to be different from  
 2 what you have the ability to do to a child in another  
 3 setting.  
 4 So I would like to explore, please, what we know  
 5 about how often the opportunity is exploited; what the  
 6 prevalence is. Because we have heard of historic cases,  
 7 but it is still happening. We know in the Davinder  
 8 case, he was convicted in 2013 of the abuse of two girls  
 9 under the age of 16 between 2010 and 2012; intimate  
 10 examinations being filmed. So it still happens.  
 11 So what do we know? Are the cases that we hear  
 12 about in the media just the tip of the iceberg? Is it  
 13 much more prevalent than that? Who would like to start?  
 14 Alison?  
 15 DR STEELE: Alison Steele, Royal College of Paediatrics and  
 16 Child Health. I think it is a really difficult  
 17 question, because I don't think we know what we don't  
 18 know. I think there may be some more robust ways of  
 19 measuring that. I know most organisations possibly --  
 20 I don't know about sort of general practice, primary  
 21 care -- have allegations-against-staff-type processes  
 22 and whether we can actually look at the data collected  
 23 in terms of returns commissioners around that, you know,  
 24 how many meetings are being held and what sort of  
 25 topics. Because it is quite a broad range of things.

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1 It is certainly not the meetings they are having are all  
 2 about sexual abuse of children. It may be any level of  
 3 allegation. But I wonder whether different  
 4 organisations have different processes and whether there  
 5 is some more data we can collect about what we do know.  
 6 Because I don't know whether we -- I'm not aware that we  
 7 collate what we could be collating, but as for knowing  
 8 what we don't know, that's extremely difficult.  
 9 MS KARMY-JONES: Let me just ask Anthony about the data  
 10 collection and the record keeping. How much is data  
 11 collated? Does the GMC, for instance, collate data of  
 12 this kind of allegation?  
 13 MR OMO: So, we do, but only where those cases are referred  
 14 to us, and I suspect that is nowhere near the number  
 15 that are dealt with locally. So we are, if you like,  
 16 the end point rather than the start point. We see the  
 17 most serious of cases, where it is public, it's been  
 18 found out, as it were, and then referred to us, and we  
 19 take action. So we have our statistics of the cases we  
 20 take action -- I don't have them to hand, but we can  
 21 provide those. But we certainly don't collate across  
 22 the NHS the numerous incidents. We do have discussions  
 23 with responsible officers about concerns in general  
 24 about doctors and those are documented, but I think  
 25 where they involve any form of abuse of children, and

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1 those become cases and are dealt with. So I'm not able  
 2 to provide statistics across the NHS.  
 3 MS KARMY-JONES: Out of interest, Anthony, just one final  
 4 thing: your statistics, is your data kept internally or  
 5 is it published?  
 6 MR OMO: So when we have cases, the outcomes are published  
 7 and we publish an annual report which shows the number  
 8 of cases, erasures, et cetera. What we don't go into,  
 9 but can provide, are the actual allegations dealt with,  
 10 or the types of allegations dealt with. So we can  
 11 provide that. We don't publish that except on request.  
 12 MS KARMY-JONES: Why is that, out of interest?  
 13 MR OMO: Just to share numbers that we would be dealing with  
 14 and the range of allegations. So we provide top-level  
 15 details of cases, what's happened, and all of that  
 16 detail is published. So any outcome from our tribunal  
 17 is published. So it is there. But what we don't do is  
 18 collate the allegations.  
 19 MS KARMY-JONES: Thank you. Christine, you wanted to say  
 20 something?  
 21 MS BRAITHWAITE: I would just say that we have just done  
 22 a categorisation project in which we have looked at how  
 23 the regulators, the nine regulators, that we oversee are  
 24 recording cases on their database. Essentially, the  
 25 regulators all categorise their cases differently. So

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1 it would be quite difficult for us currently to be able  
 2 to look across and say, "There are X number of cases in  
 3 relation to that". It is a piece of work we have been  
 4 doing recently to try to look at what research could we  
 5 undertake, carrying out the sort of data that is  
 6 collected on our own database from our review of  
 7 the final fitness to practise decisions that the  
 8 regulators' panels make, but also looking consistently  
 9 across the regulators to say, could we start to  
 10 coordinate some kind of trend collection? So that is  
 11 a very early stage of the report, but the first finding  
 12 so far is there are lots of different categories, cases  
 13 are categorised differently, so there are some  
 14 challenges in relation to pulling that data together.  
 15 MS KARMY-JONES: That is a potential problem, isn't it?  
 16 MS BRAITHWAITE: Yes, not necessarily insurmountable, but  
 17 certainly not a quick fix.  
 18 MS KARMY-JONES: John, from the NMC?  
 19 MR LUCAROTTI: We are in a similar position to the GMC in  
 20 terms of our data. Although I have to say it is only  
 21 recently that we have started categorising our  
 22 allegations in sufficient detail to be able to assist  
 23 with that sort of question. We are certainly not at the  
 24 point where that exercise has been going on long enough  
 25 for us to have confidence in exactly what that data is

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1 telling us. I also agree with Anthony's comments about,  
 2 you can only get so much of a picture from the fitness  
 3 to practise referrals and there is a lot that goes  
 4 before that which may not make its way to us, so, yes,  
 5 it does give us some information, but probably not the  
 6 full picture.  
 7 MS KARMY-JONES: Sue, does NHS England collate data?  
 8 MS BRAITHWAITE: Yes, Susan Warburton from NHS England. We  
 9 have started to collect allegations data from our  
 10 primary care review panels that we have, and it is very  
 11 early stages. What we do know is that they appear very  
 12 low, considering the large workforce that we have.  
 13 Similarly, we have conversations with the Disclosure and  
 14 Barring Service. Again, we find that the amount of  
 15 referrals from health are extremely low compared with  
 16 the volume of health professionals, which gives us cause  
 17 for concern. So we are in the early stages of collating  
 18 data of our own performers, primary care performers.  
 19 What we don't have are the range of figures across the  
 20 health sector.  
 21 MS KARMY-JONES: Is that something that you are moving  
 22 towards, then?  
 23 MS WARBURTON: We will be moving towards collecting across  
 24 the health sector. What we will be looking to do is  
 25 working with colleagues in other areas, so NMC, GMC,

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1 et cetera, Disclosure and Barring, to see if we can get  
 2 a more rounded picture of what's going on. Certainly,  
 3 having worked in local areas, similarly referrals to  
 4 LADO are very low across the country. We have looked at  
 5 that also recently.  
 6 MS KARMY-JONES: What about Wales? Simon, does NHS Wales  
 7 collect data and collate it?  
 8 MR DEAN: We don't collect data centrally, but Rhiannon  
 9 might comment from the NHS perspective.  
 10 MS BEAUMONT-WOOD: Yes, I would say the NHS organisation,  
 11 heads of named nurses, named professionals, would be  
 12 aware, or should be aware, of every concern that gets  
 13 referred. When I say "gets referred", we have a duty to  
 14 report into local authority. In Wales, we have  
 15 a structure called a professional strategy meeting,  
 16 which may be any category of child abuse, not just  
 17 sexual abuse. So we would know those numbers of  
 18 referrals from health into, and local authorities, as  
 19 I understand it, also have a data collection system  
 20 themselves and there are some returns that are provided  
 21 to the Welsh Government in terms of numbers of  
 22 categories, et cetera.  
 23 In terms of publishing, no, they wouldn't, because  
 24 obviously, at this point, it is a concern. There is  
 25 nothing proven. In addition to that, in terms of sexual

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<p>1 abuse, they are likely to be small numbers and there                  2 would be issues with small numbers guidance in terms of                  3 anonymity.                  4 So I would say we do have data. I wouldn't like to                  5 say hand on heart it would be absolutely robust, but we                  6 do have data.                  7 MS KARMY-JONES: I think, Ray, you wanted to add something                  8 to this?                  9 MR McMORROW: Yes, just a bit of clarity on data there.                  10 Certainly my experience on the designated nurses, the                  11 majority of cases of health professionals that we would                  12 refer to LADO or NMC, GMC, were actually not inside the                  13 health-related behaviours, they were private behaviours                  14 that came to the attention and led to -- so you have two                  15 different -- you have behaviours that have been carried                  16 out by health professionals but not necessarily in their                  17 health role, in their private lives, or whatever, and                  18 you have that which is carried out on patients of health                  19 services, be they NHS or private sector, and there are                  20 two different sets of data, really. I think a lot of                  21 what might come through to NMC and GMC may not always be                  22 direct practice-related stuff.                  23 MS KARMY-JONES: Trying to move slightly away from the                  24 generality of safeguarding issues, which I think                  25 everyone acknowledges and is aware of, and dealing with,</p> <p style="text-align: center;">Page 61</p>	<p>1 DR TIWARI: I think it is one of the greatest opportunities                  2 because, even if a child is chaperoned, even if there is                  3 a parent with a child on a ward, that parent will not be                  4 with that child every single minute of the day. There                  5 will always be times when the child is left, and it                  6 might just be for a few minutes. The parent will not                  7 necessarily accompany the child to the bathroom if the                  8 child is old enough to be there on their own, for                  9 example. We know that bathrooms have been places where                  10 serious attacks have taken place.                  11 Staff actually have no means of ascertaining whether                  12 the adult accompanying the child is actually related to                  13 that child. In hospitals, we don't ask for checks. You                  14 know, we don't ask for patients to provide                  15 identification to prove that they are a parent or                  16 a carer of a specific child. At the moment, that's an                  17 area really quite beyond the control of staff.                  18 MS KARMY-JONES: Should that happen?                  19 DR TIWARI: I don't know how we would implement it. It is                  20 something we have thought about. But I don't quite know                  21 how we would actually go about setting those controls.                  22 MS KARMY-JONES: Access to children is clearly part of this,                  23 and, again, those of us who have been in a children's                  24 ward may recognise the scenario of just pressing                  25 a button and being allowed into the ward by a tired</p> <p style="text-align: center;">Page 63</p>
<p>1 really, the point, where do we know children are most                  2 vulnerable? Is there a general view or does anyone have                  3 a specific view on that?                  4 DR TIWARI: I have a specific concern. With one of my other                  5 hats, I work in secondary care. I am concerned about                  6 the paediatric ward, which is essentially a mixed ward                  7 of adults and children. There are adults staying                  8 overnight in paediatric wards. There are hidden areas                  9 within the wards, and there may be some CCTV                  10 surveillance of certain public areas, but there is not                  11 total coverage, and there have been reports of abuse of                  12 children in those settings by adults who are not                  13 necessarily healthcare workers but adults visiting other                  14 children on the ward. To me, that is an area of very                  15 great risk over which we currently have no control.                  16 MS KARMY-JONES: So sometimes there are adults who may be                  17 parents who are staying, for example, overnight in                  18 a ward, and many of us may have had that experience.                  19 But equally, in some instances, where an adult does not                  20 stay with the child, the child may be left unchaperoned,                  21 which brings us back to the chaperone question.                  22 We know it happens. Plainly, we don't know the                  23 scale. So what are the greater -- you take the view                  24 that that is one of the greatest opportunities for abuse                  25 to happen? Is that right?</p> <p style="text-align: center;">Page 62</p>	<p>1 member of staff behind a desk who doesn't check you at                  2 all; maybe someone has tailgated you in through the                  3 door, and, as a parent, you won't necessarily check the                  4 person behind you. So how do we deal with that? Are                  5 there any suggestions?                  6 MS BEAUMONT-WOOD: I want to add to another area as well.                  7 It is, again, about equipping staff to be accountable                  8 and responsible for that kind of stopping and                  9 challenging anybody. Even people they are familiar with                  10 who are out of context in that particular moment. I'm                  11 particularly thinking around volunteers. You know, WLVS                  12 for example, on wards; a common sight, isn't it, with                  13 the trolley, selling bits and bobs. How do we ensure                  14 our volunteers, which we rely on -- another context is                  15 we use volunteer car drivers to take children to and                  16 from appointments. Very often, they don't have a parent                  17 in the car with them. So, actually, you know, we                  18 really -- I know it came out in the report that you did,                  19 or the findings from the feedback, the volunteer system                  20 I think is a weak link and I do think it is something                  21 that we really need to invest some workforce OD-type --                  22 systems around.                  23 MS KARMY-JONES: Sue, what about -- what views do you have                  24 on this from NHS England?                  25 MS WARBURTON: I think it would be extremely difficult to</p> <p style="text-align: center;">Page 64</p>

<p>1 implement such a system. I don't know how you would                  2 manage it on a day-to-day basis on a ward. I think it                  3 would require an extra band of staff to actually monitor                  4 the door. Whether you give people passes, as you do --                  5 I mean, I don't know whether some of you have been on                  6 holidays in Florida and you get passes to get into                  7 things, in and out of gated communities, it is a similar                  8 sort of process, but you would have to put a whole                  9 system in place and have individuals on top of -- the                  10 nursing staff would not be able to monitor that on top                  11 of the day job, I don't think. I think it is very                  12 challenging.</p> <p>13 In respect of the volunteer question, I think from                  14 an NHS England perspective, we have done a lot of work                  15 across the system around ensuring that volunteers are                  16 well vetted, that good policies and procedures are in                  17 place within hospital settings, and that we have worked                  18 with CQC so they are aware of that and they check those                  19 policies and procedures, particularly, you know, in                  20 light of recent events.</p> <p>21 So I think we have got quite a lot of those policies                  22 and procedures in place. I think what we struggle with                  23 is the monitoring on a day-to-day level.</p> <p>24 MS KARMY-JONES: So recommendations that have been made, we                  25 know that the Bradbury and the Savile cases resulted in</p> <p style="text-align: center;">Page 65</p>	<p>1 earlier, difficult to monitor that, but something has                  2 got to be done in order to provide a secure access.</p> <p>3 MS KARMY-JONES: Do you agree with the suggestion that it is                  4 almost impossible to deal with it? Or can you see that                  5 it could be done?</p> <p>6 MS CUPID: That's a difficult question. I wouldn't say it                  7 is impossible, but it will be challenging to do.</p> <p>8 MS KARMY-JONES: Is it too much of a burden to put on                  9 nursing staff?</p> <p>10 MS CUPID: I think it is not just nursing staff we have to                  11 look at. We have to look at skill mix staff across the                  12 ward and responsibilities. Nursing staff has got to                  13 juggle -- we have to look at the clinical                  14 responsibilities and responsibilities around                  15 safeguarding, both equally important. Could the needs                  16 be met by skill mix within the team, therefore freeing                  17 up the clinical staff time? That's really, really                  18 difficult. I think each service will have to look at                  19 what is required to maintain that.</p> <p>20 MS KARMY-JONES: Helen?</p> <p>21 MS CHRISTODOULIDES: Hi, I'm Helen, director of nursing from                  22 Leeds Teaching Hospitals Trust. Yes, it is too much of                  23 a responsibility to put solely on nursing staff, and we                  24 shouldn't, because it is everybody's responsibility.                  25 Wards and departments are full of multi-disciplinary</p> <p style="text-align: center;">Page 67</p>
<p>1 recommendations being made about physical access and                  2 chaperoning. How far are those recommendations in fact                  3 being followed? Clarisser, can I ask you if you have                  4 any views on that?</p> <p>5 MS CUPID: Clarisser Cupid, designated nurse, safeguarding                  6 children.</p> <p>7 MS KARMY-JONES: And also the comments about the effect on                  8 nursing staff. Can you deal with both of those?</p> <p>9 MS CUPID: I think some of the challenges that frontline                  10 nursing staff have is around the clinical care, as well                  11 as balancing that against keeping children safe on the                  12 ward. It is very difficult, and they work sometimes                  13 really hard under extreme conditions as well.</p> <p>14 I think what we can do, in order to ensure that we                  15 have a secure process in place, as much as possible,                  16 because, obviously, we want to make opportunities as                  17 little as possible for people who want to abuse                  18 children, we want to reduce that level of opportunity                  19 for them, is around access. Just having pictures on the                  20 wall so people know who staff members are and their                  21 roles and responsibilities. It is also about speaking                  22 to parents and children and identifying who their main                  23 carers are on that day.</p> <p>24 But I do know that, in particular, most wards will                  25 have a buzz-in system, but it is, as we mentioned</p> <p style="text-align: center;">Page 66</p>	<p>1 staff that have a responsibility. In fact, it is                  2 usually ward clerks and receptionists that you might                  3 find closest to nurses' stations and so on, and desks.                  4 You don't find many nursing staff sat around desks                  5 anymore. So they are often the people that do the                  6 meeting and greeting in ward areas, and of course they                  7 have had training and education around that, and there                  8 is an expectation that everyone is challenged. But it                  9 is everybody's responsibility and we have to empower our                  10 staff to do so.</p> <p>11 I think, apart from putting bouncers on doors, it                  12 almost is impossible. That doesn't feel proportionate                  13 or correct. It is very difficult. People are very                  14 busy. I walk around wards all the time and can, you                  15 know, not pass a member of staff for a couple of                  16 minutes, and that's just because, you know, they're                  17 busy.</p> <p>18 MS KARMY-JONES: Can you make any suggestions as to what                  19 could be done? You're on the hard line out there. Can                  20 you think of anything that you notice?</p> <p>21 MS CHRISTODOULIDES: Well, we could perhaps -- again, you                  22 know, perhaps we could change the geography of some of                  23 the ward layouts. It strikes me in some wards and                  24 departments you can enter and be immediately very close                  25 to patients, and some perhaps have more atriums and</p> <p style="text-align: center;">Page 68</p>

<p>1 areas that you could -- there aren't physical barriers,                  2 but navigating to get to areas seems a little bit more                  3 tricky. But then the design of buildings, we have such                  4 varied buildings and accommodation.                  5 Empowering staff. I can't really think of anything                  6 that would be easy to do.                  7 MS BRAITHWAITE: I think the issue with these things is                  8 identifying exactly what the problem is. The difficulty                  9 I see with verifying somebody on entry into a ward is,                  10 exactly what kind of check are you going to carry out?                  11 Essentially, they might tell you that they are the                  12 parent or the relative. How far would you go in                  13 relation to the check? But what confirming an identity                  14 of somebody, whether or not they have a genuine                  15 relationship with the child, doesn't do is tell you what                  16 the intentions and the motivations of that person are.                  17 So even if you were to institute a sort of type of thing                  18 you have if you go into a nightclub or some other place                  19 and you get a stamp on your wrist to say we have                  20 verified who you are, that is not going to help in                  21 relation to actually the risk to the child.                  22 It is more about what are the opportunities, where                  23 are the places that things happen, and staff being aware                  24 and vigilant about the opportunities for that type of                  25 abuse to take place, and empowering the children</p> <p style="text-align: center;">Page 69</p>	<p>1 MR OMO: Thank you, Anthony Omo, GMC. For me, it is                  2 a combination of what's been described in terms of                  3 supervision and controlled access. But I wonder if the                  4 answer lies in going back to where you started, which is                  5 do we understand the prevalence, because, if you do,                  6 then you could work out what a proportionate response                  7 is. And I don't think we have that answer. It may be                  8 different across different settings, it may be different                  9 across different countries. One answer, one solution,                  10 won't work everywhere. I do wonder if there is more to                  11 be done to get that data, understand the issue and then                  12 we can try to work out what is a proportionate response,                  13 which probably will be a combination of what's been                  14 suggested.                  15 MS KARMY-JONES: So it comes down to the fact that we don't                  16 really know, because the data isn't collated. Does                  17 everyone agree with that? No-one is disagreeing. That                  18 in itself may be seen as a bit of a problem, I suspect.                  19 What about the opportunities in community practice?                  20 We are talking about hospitals. But what about the                  21 opportunities in community practice? Does anyone have                  22 any observations about that? Rhiannon, what's it like                  23 in Wales?                  24 MS BEAUMONT-WOOD: I think the opportunity in community                  25 settings is even greater, in terms of the risks, for</p> <p style="text-align: center;">Page 71</p>
<p>1 themselves and empowering the other parents in there in                  2 terms of knowledge and what to do and how to speak out                  3 if people behave in ways that aren't that which you                  4 expect.                  5 I referred earlier to some professional boundaries                  6 guidance which we produced back in 2008, and we did                  7 a suite of guidance there for educators, for employers,                  8 for professionals and for members of the public so that                  9 everyone was clear about the behaviours that should be                  10 expected of the health professional, so that the child                  11 and patient and relative would understand what the                  12 behaviours are that should take place and, in terms of                  13 parents, also potentially advising them of some of                  14 the warnings to look out for. I think providing                  15 information and training to people about the                  16 opportunities and empowering/equipping them with the                  17 ability to be able to check and challenge and prevent                  18 that would be more effective than trying to undertake                  19 some of the more mechanical-type things, like having                  20 a bouncer on the door, and checks which also have                  21 potentially unintended consequences, in terms of                  22 the climate and the environment that it's creating in                  23 which the child and the family are having to deal with                  24 highly stressful events anyway.                  25 MS KARMY-JONES: Anthony, I think you had something to add?</p> <p style="text-align: center;">Page 70</p>	<p>1 obvious reasons: there is less people around, and it                  2 depends -- I know -- I think you said earlier about not                  3 looking at the context of "the home", but obviously, in                  4 the community context, the home is where a lot of care,                  5 and more and more care, is currently being delivered and                  6 plans to do even more delivery of care at home.                  7 So, again, I sort of took to the point Christine                  8 made. I think we need to do an awful lot more to                  9 empower the public, family members, children and young                  10 people themselves. I think an awful lot of energy needs                  11 to go into empowering individuals to understand what is,                  12 you know, within the realms of a therapeutic, proper                  13 service provision and what's crossing boundaries.                  14 I do think that we could do something, and even in                  15 acute settings, where collectively -- I say this quite                  16 deliberately -- multi-disciplinary teams could do risk                  17 assessments of the environment in which they work to                  18 understand where their weak points are. It definitely                  19 shouldn't be left to one person to say, "You have got to                  20 do the risk assessment for this quarter", it has to be                  21 done as a multi-disciplinary exercise so everybody is                  22 brought into, "This is a risk assessment" so we all                  23 collectively understand where the vulnerabilities in our                  24 working context are.                  25 I think potentially -- that doesn't happen, as</p> <p style="text-align: center;">Page 72</p>

<p>1 I understand it, at the moment specifically, but that                  2 might be something that we could explore in whatever                  3 setting.                  4 But, again, I think it is putting -- how we do some                  5 mass public awareness family context, and using third                  6 sector organisations that clearly do a lot of work in                  7 this space, like Barnardos and NSPCC, is just something                  8 we need to do a lot more in, in empowering families to                  9 increase their confidence to challenge health                  10 professionals in particular.                  11 DR STEELE: Alison Steele, Royal College of Paediatricians                  12 and Child Health. I also think we need to be cognisant                  13 of the fact that maybe some groups of children and young                  14 people are potentially more vulnerable to being abused                  15 by staff because of potentially their age, their                  16 disability, their past life experiences. Because these                  17 are often the very sort of children that people who are                  18 preying on children will actually pick, because they                  19 realise they may not be able to speak, may not be able                  20 to say, they may not be able to be believed. So I think                  21 we just need to sort of put that into the mix when we                  22 are looking at protective factors, which obviously have                  23 to be proportionate. We talked about proportionate                  24 response, and I think that's very true. If you go back                  25 to the '40s and '50s, we had children locked up in</p> <p style="text-align: center;">Page 73</p>	<p>1 same way, working with children and young people,                  2 co-producing products, and videos, and all sorts of                  3 things to raise awareness of professionals, and their                  4 parents and other children and young people, on this                  5 topic.                  6 I think we have done a range of work with Ray's                  7 group that, again, has got some really key messages. We                  8 have the Superhero campaign that is currently ongoing.                  9 I think those things are there. We will continue to                  10 work on those campaigns and build momentum. It might                  11 not be as big as the "Hello, my name is ...", as yet,                  12 but there is certainly a lot of work ongoing to promote                  13 CSC and CSA across a range of public, rather than just                  14 focusing on health professionals or focusing here, but                  15 actually raising awareness of everybody. It's been said                  16 many times today, you know, that we have to raise                  17 awareness of the public, what is acceptable, what is                  18 not, and that's the only way, rather than gating wards,                  19 which I would absolutely disagree with. We need to make                  20 sure people are aware of what's not acceptable.                  21 MS KARMY-JONES: Is there consistency, though, with other                  22 areas of healthcare?                  23 MS WARBURTON: Consistency in what respect?                  24 MS KARMY-JONES: In that kind of approach. You are doing                  25 a lot. You have outlined some of the things that</p> <p style="text-align: center;">Page 75</p>
<p>1 hospitals, it was almost like prisons, and parents not                  2 actually being able to visit them, and the damage that                  3 did to children in terms of their development, and the                  4 need, when they are sick, to have people close to them.                  5 So I think it is important to get this response                  6 proportionate, which is what people have already been                  7 discussing.                  8 MS KARMY-JONES: We have had quite a lot of observations,                  9 and it is right, it is difficult, and there are a lot of                  10 areas that it needs to cross and a lot of different                  11 settings that it falls under, but it has been done in                  12 relation to other types of things, perhaps not quite on                  13 this level, but the NHS certainly has implemented                  14 campaigns that have been successful around things like                  15 the hand washing, that is certainly something that's                  16 changed a lot, and there is a culture, isn't there, much                  17 more so now, of people being picked up on washing their                  18 hands, sanitising their hands, before they go into                  19 a ward.                  20 "My name is ..." is another campaign that has been                  21 successful.                  22 Why not this? Why can't we deal with this in                  23 a similar way?                  24 MS WARBURTON: Susan Warburton, NHS England. I would argue                  25 the point that we have done a considerable amount in the</p> <p style="text-align: center;">Page 74</p>	<p>1 NHS England are doing. What about other areas of                  2 healthcare?                  3 MS WARBURTON: I believe so. We work consistently with                  4 voluntary sector organisations, with our CQC, with                  5 Health Education England, and others. So we are getting                  6 the approaches. If you have got one message -- we are                  7 back to the one message conversation -- we haven't got                  8 one message on CSC. Maybe that's the direction we                  9 should be going, one message, rather than having several                  10 messages, because it worked in the "Hello, my name                  11 is..." campaign to have that one key message all the                  12 time. I think similarly looking at safeguarding in                  13 general about what is and what is not acceptable                  14 behaviours might be a way forward.                  15 MS KARMY-JONES: Thank you. Giles?                  16 MR DENHAM: I was going to agree strongly, I think, with                  17 Rhiannon that I think part of the answer to this is,                  18 where you don't have really good data, you do have to do                  19 a fairly specific risk assessment on the best you can.                  20 I think that is really important because actually                  21 individual wards, individual settings, think about that,                  22 they will help themselves identify where their weak                  23 points are and what might sensibly be done rather than                  24 the kind of one size fits all.                  25 Conversely, I think when you come to a campaign, the</p> <p style="text-align: center;">Page 76</p>

<p>1 ones that have worked and got quite simple, single                  2 messages, and we have done things with the voluntary                  3 sector on things like dementia, and I think Susan is                  4 right that if you do go down that route, you have to                  5 keep it simpler, but that may be a "both and" again                  6 between doing something local that is relevant to                  7 particular settings and thinking, is there something                  8 national that is straightforward we can get across?                  9 MS KARMY-JONES: Thank you. There is such a diverse range                  10 of professions that the healthcare service deals with.                  11 How do you get the message across the diverse range of                  12 professions?                  13 MS WARBURTON: Susan Warburton, NHS England. I think it                  14 is -- the professions all have safeguarding as a core                  15 within them. We are there to do no harm in the first                  16 instance. So that core is always there. It is there                  17 throughout training and education, whether you are in                  18 social care, whether you are in healthcare. So I think                  19 whatever message -- we have got doctors using "Hello, my                  20 name is ..." as well as nurses as well as physios. It                  21 is back to that core message.                  22 MS KARMY-JONES: It is also kind of back to what we started                  23 the morning with, about consistency between training,                  24 isn't it, and there are a number of healthcare                  25 professions that don't fall within the same kind of</p> <p style="text-align: center;">Page 77</p>	<p>1 MS KARMY-JONES: And how?                  2 MS WARBURTON: How? We get it into policy. We continue to                  3 support organisations. At the moment, we are looking at                  4 the "Working Together to Safeguard Children" document.                  5 It is coming to consultation. We may talk about that                  6 later. We are all working to those standards, those                  7 core standards. As we start to rewrite those standards                  8 and get the nuances of what we have learned over the                  9 past sort of three or four years in there, we will start                  10 to include other professional groups and make sure that                  11 it actually spans that body of individuals rather than                  12 just only ever looking at regulated professions, and                  13 start to encourage the system, really.                  14 MR DEAN: I wanted to build on this point about broadening                  15 it out because there are many, many occupations in the                  16 NHS, not all professions, but reporters, domestic                  17 assistants, administrative staff. That takes me back to                  18 the responsibility of the employer to make sure they                  19 have a suitably trained, experienced, supervised                  20 workforce and within frameworks set by regulatory bodies                  21 for those professions that are regulated within                  22 frameworks set by governments. I do think there is                  23 a critical responsibility on the employer to make sure                  24 this is embedded, and it comes to the subject of a later                  25 workshop into culture. For me, that is a critical</p> <p style="text-align: center;">Page 79</p>
<p>1 regulations as hospitals and GPs, and so on.                  2 So surely we must be looking to going beyond those                  3 bodies and enveloping people who maybe deal with                  4 physiotherapy or deal with other areas that are less                  5 regulated. Aromatherapy, they might put themselves                  6 forward as a healthcare professional. How does that                  7 happen? How do we encompass them as well?                  8 MS WARBURTON: I think, again, it is that message that it is                  9 everybody's business. We talk about it a lot, but                  10 safeguarding is everybody's business. No matter where                  11 you are within the broad range of healthcare settings,                  12 or providing aromatherapy, which is a very valuable                  13 thing, actually, for some individuals, the safeguarding                  14 is the core of all of that training. Whether, from an                  15 NHS England perspective, we can influence at that level,                  16 I think we probably can, by getting those key messages                  17 out there, and talking about healthcare in its broadest                  18 sense, rather than just looking at the regulated                  19 professions. We talk about -- you know, I know that                  20 within some of the training programmes now for some                  21 professions, whether it is physiotherapy, paramedic                  22 training, safeguarding, it is embedded within all of                  23 those. So we can do it. I think it is just, like you                  24 say, getting everything together with those key                  25 messages.</p> <p style="text-align: center;">Page 78</p>	<p>1 leadership responsibility. The point about risk                  2 mitigation rather than risk elimination is critical                  3 here. So where are the most significant risk issues and                  4 how do you target appropriate action that focuses                  5 specifically on those areas? It is a very important                  6 one.                  7 I currently work in a government role and have been                  8 chief executive of a number of NHS organisations and                  9 that would be certainly the approach that I would be                  10 promulgating through my organisation, to understand risk                  11 and then to take appropriate steps to take action to                  12 manage the risk and then to oversee that management of                  13 risk within the organisational context.                  14 MS KARMY-JONES: How do you go about understanding the risk?                  15 MR DEAN: I think you have to involve all staff in                  16 understanding the context within which they are working.                  17 You have to involve the patients who are experiencing                  18 that healthcare context. And there are differences of                  19 risk, whether it is the type of patient group or the                  20 geographical setting within which patients are cared                  21 for. I think it is the leadership responsibility in the                  22 broader sense to understand those risks.                  23 MS KARMY-JONES: You put that on the employer, on the                  24 individual hospital?                  25 MR DEAN: Yes. It has to start with the employer to ensure</p> <p style="text-align: center;">Page 80</p>

<p>1 they are providing a safe context within -- for staff to                  2 work and for patients to be cared for. I think others                  3 can provide frameworks, that can help, and they can                  4 provide checks and balances, but when things get to                  5 regulatory bodies, that is, sadly, often after the act                  6 has occurred. The key has got to be to prevent things                  7 happening and I do think an understanding of risk and                  8 then appropriate proportionate action in response to                  9 that risk is the right approach.</p> <p>10 What the answers to those risks are, I don't know.                  11 That's beyond my competence. But as a chief executive,                  12 that's what I would be looking for: do we understand our                  13 vulnerabilities? Do we understand the risks? Have we                  14 got the right controls in place that are proportionate                  15 to that risk?</p> <p>16 MS KARMY-JONES: Thank you. We hope -- we will try to find                  17 some of the answers today.</p> <p>18 So we have talked about -- Clarisser?</p> <p>19 MS CUPID: Clarisser Cupid, designated nurse. I just wanted                  20 to add to what was said earlier, actually.</p> <p>21 Commissioners and the local safeguarding board have the                  22 responsibility to ensure that all agencies, including                  23 all health providers, are compliant with what we call                  24 section 11, and that gives them the assurance that each                  25 provider agency and health agencies, whether</p> <p style="text-align: center;">Page 81</p>	<p>1 touched on parents having access, but there are also the                  2 cleaners, there are the locums, there are the people who                  3 come in with the trolleys. What about them? How do we                  4 regulate them? Sue?</p> <p>5 MS WARBURTON: Susan Warburton, NHS England. I think it is                  6 back to those core recruitment standards that we have                  7 put in place for things that we have learned from Savile                  8 and Bradbury about the sort of recruitment process and                  9 the Lampard review. But, also, it is back to that                  10 core -- watching people, understanding what's                  11 acceptable, what's not, and actually giving everybody                  12 the responsibility around to spot a problem and have the                  13 confidence to actually act on that. That is about                  14 culture, leadership within organisations and the way                  15 people feel within organisations to raise a concern. So                  16 I think it is very hard to actually put in a regulation                  17 around individuals and their behaviours, because                  18 people's behaviours change. So if you are okay when you                  19 walk into an organisation, two years later you may not                  20 be, and we talk a lot about Disclosure Barring and we go                  21 through all of these processes, but actually it is only                  22 good on the day you do it. So it is actually about                  23 raising the standard of education and constructive                  24 discussion across your organisation around what is                  25 acceptable and what is not.</p> <p style="text-align: center;">Page 83</p>
<p>1 commissioned or not, comply to legislation around                  2 safeguarding.</p> <p>3 It also gives us an idea as to the culture of                  4 the organisation in understanding risk and how to deal                  5 with it, whether they are a transparent agency or not in                  6 terms of, you know, raising, identifying concerns and                  7 sharing those concerns so we can learn from them as                  8 well.</p> <p>9 Now, this section 11, it is a self-assessment. It                  10 is an audit that we give out to primary care, it is                  11 given out to acute hospitals, the community health                  12 services, and everyone self-assesses to see where the                  13 gaps are in terms of risk for that organisation.</p> <p>14 Therefore, they then have to come up with a plan on                  15 how we can mitigate against those risks to ensure that                  16 we keep children safe.</p> <p>17 This is usually undertaken every year. Within the                  18 CCGs as well, providers are required to report quarterly                  19 on areas that we have identified or areas of risk and                  20 they can report that as often as possible as well, and                  21 they are challenged against those.</p> <p>22 So if there are areas of risk identified, those are                  23 things that we would expect something to be done about.</p> <p>24 MS KARMY-JONES: One of the things that's been mentioned in                  25 the answers is the position of auxiliary staff. We</p> <p style="text-align: center;">Page 82</p>	<p>1 MS KARMY-JONES: So intercollegiate guidance, I understand,                  2 specifies that all auxiliary staff should have what they                  3 call level 1 training. First of all, are they getting                  4 that? Second of all, is that sufficient? Or should it                  5 be more? Does it cover things like sexual abuse                  6 happening within the healthcare setting by colleagues                  7 who may be senior, in a position of power, over you?</p> <p>8 MS WARBURTON: My view would be, no, it doesn't. It gives                  9 people a very broad understanding of what safeguarding                  10 means. If you are very clever, you can whiz through it                  11 within a few minutes and actually not achieve very much                  12 at all. So we talk a lot about mandating training, and                  13 it has its place perhaps, but what is more important, in                  14 my view, is a training that actually educates                  15 individuals back to that original point: what is                  16 acceptable and what is not by behavioural standards.                  17 Are the professionals or auxiliary staff picking people                  18 up when it is not right? We have done quite a bit of                  19 work about sort of acceptability of behaviours and                  20 values and behaviours within the health sector. We are                  21 doing more work around values and behaviours and there                  22 is a lot more to do, in my view.</p> <p>23 MS KARMY-JONES: As I understand it, again, it is built into                  24 a standard contract for NHS services that a certain                  25 level of training should have been achieved, but how is</p> <p style="text-align: center;">Page 84</p>

<p>1 that policed? It may be in the contract box, it may be                  2 ticked, but how is it policed that it is actually done?                  3 Is it adequately policed. Christine?                  4 MS BRAITHWAITE: I don't think we know the answer to that.                  5 I don't think we would be in a position to, as the                  6 Professional Standards Authority, I'm afraid, in                  7 relation to it.                  8 MS KARMY-JONES: Do you have a view on unregulated workers?                  9 MS BRAITHWAITE: Yes, I do have a view on unregulated                  10 workers, certainly. The primary responsibility for                  11 unregulated workers has to rest with the employer,                  12 because they are the frontline in terms of making sure                  13 that the people who are working within their                  14 organisations are safe and following the organisation's                  15 policies and procedures correctly, so I completely                  16 endorse Simon's views earlier in relation to that.                  17 There are, however, other groups of workers,                  18 healthcare workers, who are not regulated by law, but                  19 nevertheless are -- and see themselves as being a part                  20 of the profession, so they may belong to a voluntary                  21 register often operated by their professional bodies.                  22 So counsellors and psychotherapists, for example, you                  23 mentioned aromatherapists. There is a register for                  24 people who practise complementary therapies too.                  25 Since 2012, our organisation was given a new role,</p> <p style="text-align: center;">Page 85</p>	<p>1 followed it using e-Learning for Health and part of                  2 the systems that works around. Again, I can only speak                  3 for my organisation, but certainly our board is                  4 interested in how many of the staff have completed all                  5 the modules of their mandatory training.                  6 Now, if you get the mandatory training content right                  7 and better, obviously it is more powerful, but, as                  8 I say, it only takes you so far. But it is one                  9 indicator of the organisation taking things seriously,                  10 I guess.                  11 MS KARMY-JONES: Again, with the e-learning and like the                  12 suggestion that it might be encompassed into CPD points,                  13 continued professional development, for example,                  14 something that came out of some of the responses that we                  15 got. Do we not again run the risk of it becoming                  16 a box-ticking exercise?                  17 MR DENHAM: You always run that risk. Equally, I suppose                  18 you are then weighing the benefits, aren't you? Is it                  19 better to have had everyone do something than nothing                  20 happen at all? As I say, it is a start. It can only                  21 take you so far. As I say, I would argue it is an                  22 indicator and it does mean it is the content that is                  23 important. There are other resources, clearly, people                  24 can make available. We produced a film earlier this                  25 year to help NHS organisations that wanted to use it --</p> <p style="text-align: center;">Page 87</p>
<p>1 which was to set standards for those organisations that                  2 hold voluntary registers and to accredit those that meet                  3 our standards. We have standards that relate to the                  4 management of risks within that and we certainly expect                  5 the organisations that we accredit to ensure that they                  6 have covered safeguarding within their education and                  7 training and that that's covered in their ethical                  8 frameworks, just as with the regulators that we oversee,                  9 all nine of the regulators we oversee, cover                  10 professional boundaries within their standards.                  11 And the registers that we accredit, similarly do.                  12 They also make reference to the professional boundaries                  13 guidance that I referred to earlier.                  14 But there is a very important gap in relation to                  15 that. I don't know whether you want me to talk about                  16 that now, because I think you want to talk about                  17 regulation and legislation this afternoon. I will come                  18 back to that point there. There is certainly a gap in                  19 relation to people who are on the voluntary register,                  20 but it is a strength and protection if people belong to                  21 an accredited register.                  22 MS KARMY-JONES: Thank you. Is there someone else who had                  23 a comment? Giles?                  24 DR DEBELLE: Yes, I'm not a salesman for mandatory training,                  25 but it is possible to measure how far people have</p> <p style="text-align: center;">Page 86</p>	<p>1 of course, it couldn't be mandated -- to help staff                  2 increase their awareness of child sexual exploitation or                  3 abuse. So there are resources out there, but                  4 ultimately, I think I would agree with Simon that                  5 employers do have to take responsibility for how they                  6 implement and how they take it seriously locally.                  7 MS KARMY-JONES: Thank you.                  8 MS BEAUMONT-WOOD: Can I add one thing, because you asked                  9 the question how do we know. In Wales, and I'm sure in                  10 England too, we have the electronic staff record.                  11 Actually, board committees do receive regular reports on                  12 compliance rates in terms of statutory manager training,                  13 of which this would be part.                  14 Colleagues across NHS Wales, my nurse director                  15 colleagues, there is some variation in terms of                  16 reliability on ESR data, because obviously it is only as                  17 good as what we put in, but there is, nevertheless,                  18 regular reporting and monitoring. So I just wanted to                  19 make that point.                  20 MS KARMY-JONES: Thank you. I would just like to move on to                  21 something that's been mentioned --                  22 MS CHRISTODOULIDES: Sorry, just to add to that, as an                  23 employer, I'm entirely responsible for those training                  24 figures and show my Trust board and commissioners, but                  25 just reflecting on the comment you made earlier about</p> <p style="text-align: center;">Page 88</p>

<p>1 the campaigns that we have had in the NHS that have been                  2 successful, I think we have all said the shortcomings of                  3 mandatory training. The way to change things is to make                  4 it uncomfortable for people in the organisation to act                  5 a certain way. So Kate Granger, the doctor who died and                  6 started the campaign around "Hello, my name is ...", did                  7 a very successful social media movement that was simple,                  8 and now it is uncomfortable on those wards where she                  9 worked -- in my hospital, actually -- to not say that.                  10 It is not written in any policy of ours, I'm sure it                  11 isn't, that you will say, "Hello, my name is Helen", we                  12 haven't written that down, we've just changed through                  13 the power of people wanting to do the right thing. Kate                  14 was, you know, a brilliant advocate for that. So it is                  15 uncomfortable now not to do that. The same with washing                  16 your hands. It is uncomfortable now -- we all look at                  17 each other when people come on to wards if you don't --                  18 well, we have gone from gelling to washing hands and                  19 backwards and forwards a couple of times. But part of                  20 that, when you mentioned that, I thought, but the                  21 prevalence of healthcare-associated infections at the                  22 time was so big that it was difficult to ignore, which                  23 made me think about our earlier points about the                  24 prevalence of this, and because we don't describe it,                  25 it's difficult, I think, to use that as a lever, but</p> <p style="text-align: center;">Page 89</p>	<p>1 going to pick up on something you mentioned earlier,                  2 Helen, and Alison mentioned as well, and that's the idea                  3 of chaperones. I wanted to ask, how well do the current                  4 arrangements -- first of all, what exactly are the                  5 current arrangements and are they consistent and then                  6 how well do those arrangements work to prevent                  7 unsupervised access during treatment? Can I turn to                  8 you, Alison, at this point?                  9 DR STEELE: Yes. Alison Steele, Royal College of                  10 Paediatricians and Child Health.                  11 I think there have always been chaperone policies in                  12 place, but I think they're actually starting to really                  13 develop more sophistication and more understanding of                  14 the issues around chaperoning, and that's recently,                  15 particularly following the recent case, the                  16 Myles Bradbury case. I think organisations have always                  17 had a chaperone policy, but it is a bit about taking it                  18 off the shelf, blowing a little bit of the dust off it,                  19 maybe, and actually thinking about, you know, the                  20 situations that chaperones are needed, who should do the                  21 chaperoning, how we train people to do the chaperoning.                  22 So having a lot more thought about it. I think that is                  23 what the recent case has actually done.                  24 So there isn't a national chaperone policy as such,                  25 but the policy that Cambridge came up with after the</p> <p style="text-align: center;">Page 91</p>
<p>1 certainly that was a significant lever in the campaigns                  2 around washing your hands. I think -- I don't know if                  3 there is a person like Kate that could, you know, create                  4 a social movement around this. I don't know if you can                  5 engineer them. But they were my reflections when you                  6 mentioned those things.                  7 MS KARMY-JONES: That's very helpful because it is                  8 a question, from what you say, of creating that sense of                  9 discomfort and that real feeling -- it is almost an                  10 emotional feeling, to make people want to comply rather                  11 than to turn a blind eye to it.                  12 MS CHRISTODOULIDES: All the staff -- all the myriad staff                  13 that have a professional body to report to have an                  14 appraisal, are much more influenced by what that culture                  15 in their ward/department/GP practice/operating theatre                  16 do; that's what changes behaviour, rather than -- there                  17 are plenty of nurses, I'm sure, that don't quite know                  18 what's in the NMC Code of Conduct, but they know how                  19 their local area operates and they know what feels right                  20 and feels wrong, and that's translating policy, isn't                  21 it, into the real world?                  22 MS KARMY-JONES: As we will come on to later, being able to                  23 voice it, feeling they are able to voice it.                  24 MS CHRISTODOULIDES: Absolutely.                  25 MS KARMY-JONES: We will come on to that. I am actually</p> <p style="text-align: center;">Page 90</p>	<p>1 case is seen as a bit of an exemplar because they                  2 obviously learnt from what happened within their                  3 organisation. So they have written a policy in response                  4 to that.                  5 I think chaperoning is very important but I do think                  6 it is not as simple sometimes as people think. It is                  7 about actually understanding -- really understanding                  8 what it is about, rather than just sort of almost going                  9 through a process because you know you have to do it.                  10 So really understanding that there is an associated risk                  11 if this isn't done appropriately, both to the patient,                  12 most importantly, but potentially to the staff as well,                  13 and how we actually train people to chaperone.                  14 I think it is very interesting because if people                  15 don't know what to expect for a certain procedure or an                  16 examination, they can't possibly chaperone that                  17 procedure and examination, because they need to know                  18 what normally happens when you do a genital examination                  19 or you take a smear or you do whatever it is that you                  20 are doing. So unless they actually are experienced in                  21 chaperoning that particular procedure, they certainly                  22 won't be in a position to challenge if anything appears                  23 to be not right.                  24 MS KARMY-JONES: So specific chaperones for specific things?                  25 DR STEELE: I personally believe that chaperones need to</p> <p style="text-align: center;">Page 92</p>

<p>1 understand what it is that's happening, whatever they 2 are chaperoning, and why they are there to do that. So, 3 again, it comes down to training, but it also comes down 4 to an ability to challenge, which I think is one of 5 the really important things about culture. So we have 6 talked about lots of things here, but it is about, you 7 know, ability to challenge anything that's blatantly 8 obviously wrong, but also how you challenge when you 9 have an uncomfortable feeling or it is not quite right, 10 how you pursue that, and having an organisation which 11 will listen to staff's concerns in those more difficult, 12 possibly grey cases.</p> <p>13 MS KARMY-JONES: So where are chaperones drawn from at the 14 moment?</p> <p>15 MS CHRISTODOULIDES: A mixture of registered and -- 16 registered nurses and clinical support workers and 17 registered nursing auxiliaries, as you described. So in 18 the outpatient settings, there's often clinical nurse 19 specialists, who will be registered nurses, either 20 running clinics alongside consultants and medical staff 21 that are often available -- this is in the acute 22 hospital setting. But equally, there are, in the 23 emergency department -- thinking of recent examples in 24 our organisation, and I do know this happens -- clinical 25 support workers, unregistered staff, are asked to go in</p> <p style="text-align: center;">Page 93</p>	<p>1 into chaperoning, but a lot of that work has been about 2 culture and being able to challenge. So the scrub nurse 3 can say to the surgeon, "I think you might be operating 4 on the wrong side", for example, but that kind of work 5 around culture and empowerment needs to go on as well as 6 training about what is it you're chaperoning, you are 7 not just standing at the room at the head of a patient 8 having five minutes off your very busy, busy job. It is 9 an active role.</p> <p>10 MS KARMY-JONES: Can I ask about chaperoning in a primary 11 care setting? Vimal, can I turn to you and then Lorna 12 about in?</p> <p>13 DR TIWARI: Yes, I think we have been very slow to become 14 aware of the responsibilities because traditionally GPs 15 have asked their practice nurses to do this when the 16 nurse is available. If there is no nurse on the 17 premises, then the receptionist tends to be pulled in. 18 So GPs are now becoming aware of the necessity to have 19 trained chaperones. In smaller surgeries, this is 20 actually quite challenging and a difficult thing to 21 accomplish.</p> <p>22 In larger surgeries, obviously there could be 23 dedicated people who are there all day and available to 24 do this. Smaller surgeries, there will quite often be 25 periods of the day when there is no suitable individual</p> <p style="text-align: center;">Page 95</p>
<p>1 and chaperone.</p> <p>2 I completely agree with what Alison says: we have 3 had examples where people clearly see chaperoning as 4 a passive role and it is not passive, it is active. 5 People, I don't think, have appreciated that enough. As 6 an employer, I feel it is my duty and responsibility to 7 enforce that and support people and get them to 8 understand, you know, what it really is there for.</p> <p>9 MS KARMY-JONES: You can imagine, actually, that if 10 a chaperone doesn't know the area of examination, for 11 example, that there's a gland check, they may not know 12 that it is not appropriate, for example, for the gland 13 check to descend down to the breasts or other areas, so 14 there must be quite a high level of training or 15 specificity to who chaperones what.</p> <p>16 MS CHRISTODOULIDES: Yes, and that is a gap currently that 17 we will address, but that's certainly a gap. And people 18 have to have -- you know, we have talked about having 19 the ability to challenge that authority gradient that 20 exists between professions and pay bands and within the 21 hierarchy. We have actually worked really hard in, for 22 example, operating theatres to make sure that checks are 23 in place and people can challenge learning from the 24 aviation industry about checks, and some of the work -- 25 I'm not suggesting we put -- well, we might put checking</p> <p style="text-align: center;">Page 94</p>	<p>1 available, and so there is a real gap. I think there is 2 also not a clear enough understanding of the role that 3 Alison described so graphically of the active chaperone 4 and of the chaperone being aware of the intricacies of 5 every examination and what needs to happen and having 6 the power to challenge.</p> <p>7 So these are all going to be difficult to implement 8 in general practice. Obviously, we will have to do it. 9 It is going to require a large education campaign.</p> <p>10 MS KARMY-JONES: It is interesting, the idea of 11 a receptionist being pulled in is odd.</p> <p>12 DR TIWARI: It is.</p> <p>13 MS KARMY-JONES: Would you say that that is a chaperone who 14 is there more for the protection of the practitioner 15 than the patient in those circumstances?</p> <p>16 DR TIWARI: Traditionally, historically, it has been for the 17 protection of the practitioner and in fact it has not 18 been a very good protection, because often the 19 receptionist will stand somewhere distant from the 20 examination couch and will try and not intrude upon the 21 process, will try to preserve the patient's modesty. 22 So, for example, in an intimate examination, the 23 receptionist would be at the patient's head, perhaps 24 talking to the patient, and not paying any attention to 25 what's happening lower down.</p> <p style="text-align: center;">Page 96</p>

1 So it has been totally inadequate as a process all  
 2 round. It doesn't protect anyone. So, yes, that  
 3 obviously needs to change.  
 4 MS KARMY-JONES: So that focus may need to shift. Lorna, do  
 5 you have any views on this from the Welsh perspective?  
 6 DR PRICE: Not particularly from a Welsh perspective, but  
 7 from the perspective of a community paediatrician who  
 8 has been practising for quite a long time, I think it  
 9 used to be, when we did clinics in the community, we  
 10 always had a nurse with us, and then they were withdrawn  
 11 and there was a little bit about, "Oh, it wasn't  
 12 a suitable activity for a nurse to be a doctor's  
 13 handmaiden in a clinic setting", but I have had very  
 14 good experiences of working with nurses, usually doing  
 15 child protection assessments, where they are more than  
 16 a chaperone and really an advocate for the child, and  
 17 certainly are able to challenge if they feel that things  
 18 aren't being done as they should be.  
 19 That's just my reflection on the conversation.  
 20 MS KARMY-JONES: Thank you. John, do you have anything on  
 21 this? Any observations?  
 22 MR LUCAROTTI: I don't have anything to add on this.  
 23 MS KARMY-JONES: Is there anyone else who wants to add  
 24 anything around this at this point, before I move to  
 25 taking some questions or comments from the public

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1 gallery? Yes, Clarisser?  
 2 MS CUPID: Clarisser Cupid, designated nurse. It is just to  
 3 add to the fact that it is not just about challenging,  
 4 but being able to escalate the concern if they do have  
 5 a concern. I think, within health, we work very closely  
 6 with our colleagues and may not necessarily feel  
 7 confident, if we do raise a concern, what we need to do  
 8 about it. So it is about being able to escalate it and  
 9 that there are safeguards to protect us if we do have to  
 10 escalate the concern as well.  
 11 MS KARMY-JONES: Is that a potential problem with it being  
 12 managed locally, so managed by the employer, do you  
 13 think?  
 14 MS CUPID: I think potentially it can be. It depends on  
 15 probably the person undertaking the examination and the  
 16 person who is actually raising the concern, because it  
 17 is a power balance or imbalance. So it potentially can  
 18 be. But I think we have actually got -- we have learnt  
 19 from recent cases -- the Bradbury case, for example --  
 20 and we know there are now safeguards in place that can  
 21 protect people to push things forward if they need to.  
 22 MS KARMY-JONES: We are coming up to the 10-minute time.  
 23 Yes, Alison?  
 24 DR STEELE: I'm really sorry, but I just wanted to bring to  
 25 the panel's attention another topic, and that's around

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1 recruitment and the value-based interviewing. Obviously  
 2 we rely on lots of checks and DBS checks and points  
 3 systems in interviews and we rely on references, but  
 4 there is something called value-based interviewing,  
 5 which I'm not in any way an expert at, and I haven't  
 6 actually done it but I've seen a presentation around it  
 7 and it is around putting scenarios to people and asking  
 8 them what they see in that scenario. My understanding  
 9 is you can actually pull out people's values and  
 10 approaches from that, which is actually sometimes far  
 11 more telling than their references, so it is just  
 12 a thought to maybe look into that a bit further.  
 13 MS KARMY-JONES: Some people I think are leaving us this  
 14 afternoon. Is there anyone who is leaving us this  
 15 afternoon who wants to make a final observation on this  
 16 point before I move to the public gallery? This is your  
 17 last chance.  
 18 Let's turn to the public gallery, then. I am going  
 19 to go to Chris, who is sitting in the public gallery.  
 20 Observations from the public gallery  
 21 MS TUCK: Hi, everyone. My name is Chris Tuck and I am  
 22 a survivor myself. Just a few things: the key message  
 23 is zero tolerance to child sexual abuse. That is the  
 24 clear and ultimate message. It, in itself, is powerful  
 25 and uncomfortable and will make people stand up, and

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1 that becomes the culture and that becomes your practice,  
 2 that becomes your policy, "If you see or hear anything,  
 3 this is the policy, this is the procedure, this is what  
 4 you need to do in order to safeguard children and  
 5 safeguard yourselves".  
 6 I just want to know, really, what the whistleblowing  
 7 policy is in all your organisations and what effect that  
 8 has on the whistleblowers and have people left their  
 9 jobs because of it, and things like that. So do you  
 10 protect your whistleblowers? If we have a culture of  
 11 zero tolerance to child sexual abuse, maybe we don't  
 12 need a whistleblowing policy because everybody is on the  
 13 same page.  
 14 One question that I want to put forward is, how do  
 15 health services involve survivors in their training, as  
 16 survivors are the experts by experience? That's  
 17 a question I would like some sort of clarification on,  
 18 please.  
 19 How are GPs vetted, because obviously, as you said,  
 20 some GP practices are one or two people and some are  
 21 great big groups of doctors. So how are they vetted and  
 22 how is child sexual abuse, you know, practice vetted in  
 23 that incidence?  
 24 I worked in a healthcare setting for six years,  
 25 working with patients as a fitness therapist, and

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<p>1 I would be on my own with vulnerable people, vulnerable                  2 patients. Often, the wards were understaffed, there was                  3 a high level of agency staff and there was no time to                  4 teach these agency staff, which had a high turnover,                  5 about policy and procedure, so how is that looked at and                  6 operated?                  7 The staff there knew me and they trusted me. Maybe                  8 sometimes that trust is misplaced. Sometimes you get                  9 too comfortable with the people that you are around and,                  10 you know, you like them, you trust them, you know them,                  11 or so you think, and this is where perpetrators often                  12 pop up. So how do we acknowledge that and pay attention                  13 to that, really? Thank you.                  14 MS KARMY-JONES: Thank you. We will come back to some of                  15 those after lunch. Thank you very much for those                  16 observations.                  17 Mr O'Mara?                  18 MR O'MARA: Nigel O'Mara, East Midlands Survivors.                  19 The question of chaperones, what Dr Steele was                  20 saying earlier. I think we can go a little bit further                  21 than that, because if somebody isn't trained properly                  22 and abuse does take place, then they are seen as                  23 condoning that abuse by the survivor. They are seen as                  24 being part of that abuse by the survivor. So unless                  25 there is proper training and proper resources put into</p> <p style="text-align: center;">Page 101</p>	<p>1 public gallery?                  2 Does anyone wish to address any of the points raised                  3 there now or would you like to take lunch and reflect on                  4 some of those and we will come back to them? Shall we                  5 do that?                  6 DR TIWARI: I can talk about checks on general                  7 practitioners. I'm Vimal Tiwari from the Royal College                  8 of General Practitioners. Any general practitioner                  9 starting a new post is required to have a Disclosure and                  10 Barring check. A subject of debate is then how often                  11 these checks should be repeated, because, at the moment,                  12 there is no mandated time interval. So a GP can go                  13 20 years in the same post without having any further                  14 checks, and of course circumstances change. And the                  15 same applies to our staff. So we ask them -- we check                  16 our staff at the time of recruitment, but what do we do                  17 about the very dear, well-loved people who have been                  18 with us for decades?                  19 MS KARMY-JONES: Circumstances change and behaviour changes                  20 and how do you check behaviour?                  21 DR TIWARI: And also relatives. They may have people at                  22 home who are abusers and they may be passing on                  23 information about vulnerable patients. That is one of                  24 our great concerns in general practice. So how do we                  25 control it?</p> <p style="text-align: center;">Page 103</p>
<p>1 it, it could end up adding to the problem rather than                  2 taking away from it.                  3 Now, I think a way that that could be possibly                  4 achieved is very similar to the pupil premium that's put                  5 into schools. Has a vulnerable patient premium been put                  6 into hospitals and healthcare settings where, when they                  7 have people who are vulnerable, they get a budget to be                  8 spent on chaperoning and training?                  9 MEMBER OF THE PUBLIC: One comment on the children's wards                  10 in hospitals, the security there. Now, if I take the                  11 little lad out with me, he's 6, and I talk to                  12 a stranger, the mother goes mad, "Don't talk to                  13 strangers", this is what we get nowadays. Yet, if                  14 I walk into a ward and it's a children's ward and                  15 there's a mother in front of me, she'd open that door                  16 and I'd just walk in behind her. I don't know, because                  17 I haven't been for a long time, but surely, if they're                  18 doing it to me, the kids are doing it -- "You can't talk                  19 to strangers", this should be put on. I think a lot of                  20 it should be on the responsibility of the people going                  21 to them hospitals to make sure they don't let strangers                  22 just walk in behind them and just put the notices on,                  23 "Please make sure you know who is behind you". That's                  24 all I'm saying.                  25 MS KARMY-JONES: Thank you. Is there anyone else in the</p> <p style="text-align: center;">Page 102</p>	<p>1 MS KARMY-JONES: Food for thought, perhaps, chair, over the                  2 lunchtime adjournment.                  3 THE CHAIR: Thank you very much. And thanks to everybody                  4 present for a very interesting discussion in this part                  5 of the morning.                  6 We will reconvene at 2.00 pm. Thank you to anybody                  7 who will not be returning this afternoon. We will see                  8 you at 2.00 pm.                  9 (1.00 pm)                  10 (The short adjournment)                  11 (2.00 pm)                  12 Session 2: Opening remarks by MS KARMY-JONES                  13 MS KARMY-JONES: My name is Riel Karmy-Jones. I am                  14 facilitating this seminar. Can I just note we have got                  15 some changes in participants from the morning session.                  16 Welcome, all.                  17 Briefly, I am going to just recap: my role is just                  18 to assist the conversation, the discussion, the debate.                  19 There will be some gentle challenges to some of                  20 the things that are said. But we are not here to                  21 cross-examine anyone. I just ask that, where comments                  22 are made, that they are directed through me and                  23 discussions and debates don't spring up between people                  24 across the table, because it makes it very difficult for                  25 those who are following on the video feed to follow.</p> <p style="text-align: center;">Page 104</p>

<p>1 As a general rule, could I ask everyone to give 2 their names and which organisation, if any, they are 3 representing when they give an opinion or a view or an 4 answer to a question.</p> <p>5 At the end of each session, before the breaks, we 6 will invite some observations from the public gallery. 7 I am going to, in a moment, ask everyone, in fact, so 8 that everyone knows, to introduce or re-introduce 9 themselves and their organisation, and perhaps I could 10 just ask the new people to tell us what they are hoping 11 to achieve or gain from the session that they are 12 attending today. So can I start with you, again, 13 Anthony.</p> <p>14 Introductions</p> <p>15 MR OMO: Yes, thanks. Anthony Omo, director of fitness to 16 practise and general counsel at the General Medical 17 Council.</p> <p>18 MR HEANEY: Good afternoon. Albert Heaney, Welsh Government 19 director for social services and integration.</p> <p>20 MS BRAITHWAITE: Good afternoon. Christine Braithwaite, 21 director of standards and policy at the Professional 22 Standards Authority.</p> <p>23 MR DE SOUSA: Good afternoon. Eustace de Sousa, national 24 lead for children, young people and families in Public 25 Health England, sponsored by the Department of Health.</p> <p style="text-align: center;">Page 105</p>	<p>1 MS BEAUMONT-WOOD: Rhiannon Beaumont-Wood, an executive 2 director of quality, nursing and allied health 3 professionals in Public Health Wales, but here today 4 representing nurse directors NHS Wales.</p> <p>5 MR DEAN: I'm Simon Dean, deputy chief executive of 6 NHS Wales.</p> <p>7 DR CHAMBERLAIN: Kate Chamberlain, chief executive of 8 Healthcare Inspectorate Wales, and I'm here really 9 because I'm interested in how we can use what we do 10 effectively to support improvement in the services and 11 make sure things are being done to the most effective 12 way.</p> <p>13 MR LUCAROTTI: John Lucarotti, head of policy and 14 legislation at the Nursing &amp; Midwifery Council.</p> <p>15 MR VINEALL: I'm William Vineall, director of acute care of 16 quality at the Department of Health and in respect of 17 today, my responsibilities are particularly that, 18 whistleblowing, speaking up and investigations. When 19 I was doing the investigations work, I had the oversight 20 of the Jimmy Savile investigations that the department 21 did. So what I am interested in is how our general 22 messages about learning and accountability can be 23 applied in this sphere.</p> <p>24 DR TIWARI: Vimal Tiwari, safeguarding GP representing the 25 Royal College of General Practitioners.</p> <p style="text-align: center;">Page 107</p>
<p>1 MS WARBURTON: Susan Warburton, NHS England.</p> <p>2 MS HORSLEY: Angela Horsley, head of children, young people 3 in transition, NHS improvement. I'm hoping to gain, 4 I suppose, a better understanding of where 5 NHS Improvement, as a relatively new organisation, fits 6 into the bigger picture and to get safeguarding in its 7 entirety higher on the agenda.</p> <p>8 MS GALLAGHER: I'm Professor Ursula Gallagher, deputy chief 9 inspector at the Care Quality Commission. In that 10 responsibility, I am the national lead for safeguarding 11 and also for the inspection and regulation of children's 12 services and people in the criminal justice system.</p> <p>13 MS CUPID: Clarisser Cupid, designated nurse for 14 safeguarding children for Southwark CCG, Clinical 15 Commissioning Group.</p> <p>16 MS CHRISTODOULIDES: Hello, I'm Helen Christodoulides. I'm 17 a director of nursing at Leeds Teaching Hospital Trust.</p> <p>18 MR FRANK: Good afternoon. My name is Ivor Frank, I'm 19 a member of the inquiry panel.</p> <p>20 THE CHAIR: I'm Alexis Jay and I'm the chair of the inquiry 21 panel.</p> <p>22 PROF SIR MALCOLM EVANS: Malcolm Evans, member of 23 the inquiry panel.</p> <p>24 MS SHARPLING: Drusilla Sharpling, member of the inquiry 25 panel.</p> <p style="text-align: center;">Page 106</p>	<p>1 DR PRICE: Lorna Price, designated doctor national 2 safeguarding team, Public Health Wales.</p> <p>3 Session 2: Opening remarks by MS KARMIY-JONES (continued)</p> <p>4 MS KARMIY-JONES: Thank you very much. Just by way of 5 reminder, in terms of specific enquiries and 6 investigations, I think there is more than one person 7 here who has had some involvement in some of 8 the high-profile investigations that have taken place in 9 recent years. Just bear in mind, we are not going to 10 deal with the detail of those inquiries or 11 investigations, and we are going to try to avoid 12 mentioning specific names and specific organisations -- 13 that's a comment as much for the public gallery, should 14 anyone wish to make any comment later. We are on a live 15 video feed and, if anything inappropriate is said that 16 might trespass on inquiries or investigations in other 17 spheres, we will cut the feed. There is a five-minute 18 delay that some of you are already aware of. Just as 19 a safeguarding measure that we have, we will cut the 20 feed to ensure that nothing goes into the public domain 21 that shouldn't.</p> <p>22 This morning's focus, there was a lot of generality, 23 a lot of good stuff came out of this morning, a lot of 24 generality. I just want to remind everyone, and 25 certainly the new participants, that we do want to focus</p> <p style="text-align: center;">Page 108</p>

<p>1 on difficult questions around what isn't working, what                  2 is working well, what needs improvement, what is                  3 standing in the way of improvement, how are we going to                  4 improve things, how are we going to prevent child sexual                  5 abuse within a healthcare setting, and what real                  6 difference will solutions make? What solutions do you                  7 suggest? Can you suggest any? What real difference                  8 will they make? Why would you do the thing that you may                  9 suggest?                  10 So we do hope to get some answers to some of                  11 the difficult questions today.                  12 Discussion re Topic 2                  13 MS KARMY-JONES: I just want to pick up on some -- to follow                  14 up on some of the questions that arose this morning.                  15 One of the points that came up this morning was that                  16 children are, on occasion, still being treated in adult                  17 settings. I want to ask whether there is any                  18 understanding about how often that happens and why. Can                  19 anyone help with how often that happens and why? Let's                  20 turn to the Welsh position? Rhiannon? Does it happen                  21 frequently in Wales?                  22 MS BEAUMONT-WOOD: So it happens, but I wouldn't say it                  23 happens frequently. If it does happen, then a risk                  24 assessment is undertaken to ensure that mitigations                  25 obviously are put in place to safeguard the young person</p> <p style="text-align: center;">Page 109</p>	<p>1 option, not because it is preferable.                  2 MS KARMY-JONES: Is it in part, do you think, because there                  3 are insufficient resources or units available that are                  4 specifically geared towards children? I mean, mental                  5 health is an easy one to focus on.                  6 MS WARBURTON: Again, Susan Warburton, NHS England.                  7 Yes, I do believe that. I think we do struggle to                  8 accommodate, at times, the needs of some young people in                  9 the most appropriate setting and it is, as you quite                  10 rightly say, the least worst option. There has been                  11 a lot of work, I have to say, across NHS England                  12 recently to look at what we need to commission                  13 differently and work with local authorities to                  14 commission those placements. But we still have a bit of                  15 a way to go.                  16 MS BEAUMONT-WOOD: I think the other thing is being very                  17 child-centred -- child- and young-person-centred in the                  18 decision making. Obviously, at a point in time when you                  19 need to have your family in reasonably close proximity,                  20 choosing a place of care that's closest to home has to                  21 be equally considered in the decision-making process.                  22 MS KARMY-JONES: Right. So people sometimes might be made                  23 to move, you mean, move away from their families, so                  24 sometimes they might be put into an adult setting                  25 because that's closer, the proximity may be closer?</p> <p style="text-align: center;">Page 111</p>
<p>1 in that setting.                  2 MS KARMY-JONES: Sue, NHS England?                  3 MS WARBURTON: I think, similarly, it does happen across the                  4 health sector in England. We aren't particularly good                  5 at monitoring it. I think we could be a lot better at                  6 how we monitor those occurrences because the figures,                  7 again, don't translate often to the reality.                  8 MS KARMY-JONES: We did just a brief check and found that in                  9 2014/2015, 391 children were treated in adult mental                  10 health wards in England. That's just in the mental                  11 health ward section. Can that ever be justified and, if                  12 so, why is there a justification and what is it?                  13 MS WARBURTON: I think initially we look at the individual,                  14 so when you say you have got a child in a mental health                  15 ward, I think sometimes it is the circumstances by which                  16 they have landed there, and sometimes it might be the                  17 most appropriate setting and the safest setting, given                  18 the circumstances for that child. It depends whether we                  19 are talking child or young person. So I think we just                  20 need to understand that, in the first instance.                  21 But, as a rule, there shouldn't be an instance,                  22 unless it's been truly risk assessed that that's the                  23 most appropriate place for that child to be.                  24 MR VINEALL: I was only going to say, I'm no expert on this,                  25 but I'm sure it happens because it is the least worst</p> <p style="text-align: center;">Page 110</p>	<p>1 MS BEAUMONT-WOOD: Obviously, the first decision would be to                  2 choose an appropriate setting which is geared up for                  3 children, young people. But when, then, you are                  4 considering about numbers of beds, et cetera, et cetera,                  5 the other thing to take into consideration is, I'm                  6 saying, about having access to your family, and that                  7 they can come and spend time with a young person who has                  8 been admitted. So I think it is taking all of those                  9 things into consideration when deciding where to place                  10 children for care.                  11 MS KARMY-JONES: Can it ever be justified, placing children                  12 now in an adult setting? Ursula, do you have a view                  13 from the CQC, Care and Quality Commission, perspective?                  14 MS GALLAGHER: I think there is a policy view that says,                  15 while, as we have heard, it is sometimes unfortunately                  16 the least worst option, as William said, it is not                  17 something that we should -- the system should either be                  18 complacent about or not, on occasions, feel very                  19 distressed about it, itself. I think we, as you may be                  20 aware, are in the middle of carrying out a review into                  21 child and adolescent mental health services, the first                  22 paper of which will be published in the middle                  23 of October, and, again, I think some of the other issues                  24 relate to the complexity of the children and young                  25 persons' presentation, and, again, in my work, I also</p> <p style="text-align: center;">Page 112</p>

1 see many children and young people who come to the  
 2 attention perhaps through the criminal justice route, so  
 3 it is not only about child and adolescent mental health  
 4 services, it is about the interface with police, prisons  
 5 and other places of safe custody, and, again, whether  
 6 those settings have the right balance of safety and  
 7 therapeutic intervention in order to attempt to improve  
 8 the life chances of those children and young people in  
 9 those complicated circumstances.

10 We recognise what colleagues have said, but the work  
 11 that we are doing does indicate that planning, good  
 12 partnership relationships and effective leadership will,  
 13 to try to do something differently, means there are  
 14 certain parts of the country that are doing really well  
 15 with this and there are certain parts of the country  
 16 that are doing less well. It is a universal challenge,  
 17 but the ability to respond to the challenge varies  
 18 across the country.

19 MS KARMY-JONES: The ability to respond or just the way the  
 20 responses are being dealt with?

21 MS GALLAGHER: Both.

22 MS KARMY-JONES: How can we address that? What's the  
 23 problem and how can we address it?

24 MS GALLAGHER: So I think, from our work, one of  
 25 the challenges always is the focus and the skills in any

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1 particular area to think about how you assess those  
 2 needs of children and young people, how you are  
 3 involving clinicians and parents and service users  
 4 themselves in the planning and development of  
 5 appropriate models of care, particularly how early  
 6 identification systems is always a difficulty if a child  
 7 presents in absolute crisis unknown to the system, and  
 8 that's where you are in the least worst option  
 9 situation, but it is about where partners work well  
 10 together to address those vulnerabilities and where  
 11 there is a leadership passion and will that can make  
 12 a difference, but people are battling competing  
 13 priorities at the moment. Sometimes the needs of very  
 14 small numbers of children and young people are not  
 15 always heard in a very complex health and social care  
 16 system.

17 MR VINEALL: I was going to add that one of the reasons the  
 18 cross-cutting reviews Ursula mentioned are so useful is  
 19 because you get a look across a system. For instance,  
 20 if you just look at a hospital, you just look at a local  
 21 authority or somewhere else, you will see a bit of  
 22 a problem. Often, if you look across the piece, you can  
 23 see there is a shortfall in totality or it is one  
 24 institution that the others are making up for, but it  
 25 gives you the picture, because, for health, it is not

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1 a single isolated issue. So the fact that CQC is  
 2 a regulator across health, social care, mental health  
 3 gives us a better picture.

4 DR TIWARI: Just to add to something Ursula has touched on,  
 5 in general practice, we struggle with the gaps and  
 6 deficiencies in mental health provision for children and  
 7 young people in some parts of the country. It is very  
 8 limited, tiers 1 and 2 provision, so children are not  
 9 being helped and supported at the first presentation,  
 10 and what service users themselves have said in a number  
 11 of different research projects, that if they had had the  
 12 help earlier, they would not have presented in crisis.

13 So I think there is a huge amount of work to be done in  
 14 delivering appropriate services upstream.

15 MS KARMY-JONES: How would you address that? A huge amount  
 16 of work to be done. Where do we start?

17 DR TIWARI: Putting an investment into tiers 1 and 2  
 18 services and ensuring they are effectively monitored and  
 19 regulated.

20 MS KARMY-JONES: Angela?

21 MS HORSLEY: Angela Horsley, NHS Improvement. Again, just  
 22 following on from that as well, hopefully, some of  
 23 the monies that came from the future in mind could  
 24 potentially be directed to changing some of those models  
 25 of care for children and young people. But of course,

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1 in order to get the appropriate model of care, you also  
 2 need the correct workforce as well, and at the moment we  
 3 are fishing out of a very small pool of people. So  
 4 there are things called the Children and Young People's  
 5 IAPT, and that's the access to psychological therapies,  
 6 and there is a lot more collaboratives now being formed  
 7 throughout England to really start to recognise the need  
 8 to, you know, train up more healthcare professionals for  
 9 that.

10 MS KARMY-JONES: One of the things that was raised before  
 11 the break was the question of ward architecture as  
 12 a method of perhaps helping to prevent child sexual  
 13 abuse in a healthcare setting, specifically obviously in  
 14 a hospitalised setting. We just wanted to probe  
 15 a little bit on that and to see what the views were  
 16 around that. Is it a realistic or a helpful thought  
 17 that wards could be designed in such a way as to prevent  
 18 or assist in the identification of child sexual abuse or  
 19 is that a red herring?

20 MR DEAN: I don't think it is a complete red herring, but  
 21 I think we need to just be conscious of  
 22 the practicalities. NHS in Wales, I'm sure the same is  
 23 true in England, has a massive amount of estate of  
 24 variable age and variable design and variable quality.  
 25 I would expect that any new build or refurbishment,

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<p>1 taking account of any key constraints, would make sure                  2 that there is a whole range of factors taken into                  3 account, and this should be one of them, making sure                  4 that patients can be cared for as safely as possible.                  5 But it would be a significant, costly, lengthy                  6 proposition, I would suggest, to remodel the whole NHS                  7 estate with that in mind.                  8 MS KARMY-JONES: There is a lot of new build going up,                  9 I think, in England certainly, and resources is                  10 obviously something that's going to run through a lot of                  11 these discussions underlying this, do we have the money,                  12 can we find the resources through which to deal with the                  13 issues.                  14 Can I just ask Ursula, is it something we hide                  15 behind? Is resources something that gets hidden behind                  16 to stop actually dealing with the problem? That's not                  17 an accusation to you -- it is not meant that way. This                  18 is something that comes up in a number of different                  19 areas across these discussions.                  20 MS GALLAGHER: I think we would all -- it would be                  21 a disservice not to say, of course, there is a resource                  22 challenge, but I think what we would say in our work is                  23 that there is sufficient and very clear variation of                  24 response that is not simply linked to disparity of                  25 resources. So the choices and the priorities that areas</p> <p style="text-align: center;">Page 117</p>	<p>1 the newer designs -- so balancing out the lines of sight                  2 with the privacy and dignity conversation with the                  3 single room conversations aren't easy, but I think that                  4 we are recognising, particularly where we are needing to                  5 make best use of workforce and think about how it is                  6 that workforce works, I think the other thing that would                  7 go alongside that is designing in some of the technology                  8 issues. I think it is a combination of architecture and                  9 technology that, again, in some of the best places that                  10 we have seen there are some of those very good examples                  11 of really creative thinking in those areas that would                  12 address a number of safety concerns, including reducing                  13 opportunities for abuse.                  14 MS HORSLEY: Angela Horsley, NHS Improvement. Again, just                  15 thinking about the 391 of children who were admitted to                  16 adult mental health wards, there is a lot of                  17 children/adolescent mental health patients who are now                  18 admitted to general paediatric wards as well. Again,                  19 I think just sort of like taking into consideration some                  20 of what Ursula said, I think there is something very                  21 important about knowing who children and young people                  22 are who are going to be admitted and really mitigating                  23 the risks, because those numbers are increasing as well.                  24 MS KARMY-JONES: Thank you. William?                  25 MR VINEALL: I just wanted to answer on both points on</p> <p style="text-align: center;">Page 119</p>
<p>1 make, the way in which they identify and prioritise the                  2 needs of their population and the way in which they work                  3 together means that you can have a look at areas that,                  4 on the face of it, seem to have, however you look at it,                  5 in terms of capitation funding or size of workforce that                  6 are delivering very different outcomes, both in terms of                  7 clinical outcomes and service user experience. So                  8 I think we always need -- and we would hope in our                  9 role -- both to be challenging about that but also to be                  10 able to be a conduit for some of that best practice and                  11 in our encouraging/improvement role, that's what we                  12 would see and help people to connect between those that                  13 are doing better and those that are doing less well.                  14 MS KARMY-JONES: Just to finish on the architectural point,                  15 is there anyone else who has an appetite for that view                  16 of remodelling wards?                  17 MS GALLAGHER: Can I just say something, because obviously,                  18 from our perspective, that does very much fit in                  19 a broader conversation about the role that architecture                  20 might play in a whole number of aspects of safety and                  21 the delivery of safe care, and there are some issues                  22 about how you think about preserving lines of sight.                  23 I'm very elderly in this room, but while there were lots                  24 of things against the old Nightingale Ward, I could sit                  25 at one end of it and look down the whole of it. Some of</p> <p style="text-align: center;">Page 118</p>	<p>1 resources and design. Certainly when there was all the                  2 work done about safe staffing levels three or four years                  3 ago, one of the issues that came up as a part of it was                  4 the question, a little bit, about design of institution                  5 because certain designs allow you to more effectively                  6 deploy your capability. So it is definitely a factor.                  7 On the question of resourcing, there is some work                  8 going to be starting shortly, which has sort of been                  9 developing this year, which will be looking at use of                  10 resources and being more explicit through CQC in                  11 conjunction with NHSI about how a group of resources is                  12 used in a certain area, be it for the area we are                  13 talking about now or others. So that would start to be                  14 a partial answer to that question.                  15 DR TIWARI: Just to reinforce what Ursula has just said,                  16 there is a considerable overlap between patient safety                  17 generally, staff safety and safeguarding. There has                  18 been some work done on creating safe spaces in schools.                  19 There has been a piece of research. And on finding                  20 solutions to unsafe spaces, which are not necessarily                  21 expensive. It is about using spaces in a different way.                  22 So I think it is possible without vast investment.                  23 MS KARMY-JONES: Thank you. Christine, I think you had                  24 something you wanted to add to that?                  25 MS BRAITHWAITE: Thank you. Just in relation to resources.</p> <p style="text-align: center;">Page 120</p>

<p>1 Christine Braithwaite, Professional Standards Authority.                  2 Just in relation to Vimal's point earlier about tiers 1                  3 and 2 and children getting support earlier on to prevent                  4 them ending up presenting in crisis, and that is that                  5 there is still a tendency to think about workforce                  6 issues in relation to the workforces that people already                  7 know about and are used to using, and just to flag up                  8 that there are 50,000 counsellors and psychotherapists                  9 on accredited registers, some of whom work currently                  10 within the NHS. So child psychotherapists, for example,                  11 are employed within the NHS, but a vast number of them                  12 who work independently outside of the NHS, but                  13 nevertheless are available and could be made use of in                  14 terms of future planning for workforce and resourcing of                  15 mental health services for children who aren't currently                  16 considered. Just to flag that up.                  17 MS KARMY-JONES: It does bring us on to the next point which                  18 is again from this morning, that obviously there are                  19 a lot of people who move in and out of organisations, be                  20 they locums, agency staff, clinical rotations,                  21 residents, contract and temping staff. Arising from                  22 this morning is the question of how people are vetted,                  23 how we apply a standard to all of the workforce,                  24 including agency staff, and even volunteers, and ensure                  25 that those people are -- that we get the right people</p> <p style="text-align: center;">Page 121</p>	<p>1 a bit of time. Of course, they don't have the same                  2 staying power to stick to that process as people who are                  3 coming for a paid job. That would be my reflection.                  4 MS KARMY-JONES: One of the things that arose before                  5 lunch -- Vimal, you mentioned this about the DBS checks                  6 and them not being done frequently enough. One of                  7 the questions we had was how well, in general, current                  8 arrangements are working for pre-employment checks. It                  9 seems they are not working terribly well.                  10 Also tied in with that is the question of, even if                  11 the DBS checks are done more regularly, will that                  12 actually really assist, because aren't they only as good                  13 as -- well, it is only if something comes up in the                  14 20 years that they will pick up on something, won't                  15 they?                  16 DR TIWARI: Vimal Tiwari, Royal College of General                  17 Practitioners. We have thought about how to tackle                  18 this. One idea was self-declaration: asking staff at                  19 their annual appraisal whether anything in their                  20 circumstances has changed. So we are dependent on staff                  21 disclosure. I don't know how well that would work.                  22 Because a DBS check is a snapshot, it is that moment in                  23 time. It is not very meaningful. I mean, it can be.                  24 It's the possibility and the likelihood and the risk                  25 assessment. I mean, how likely is it that somebody who</p> <p style="text-align: center;">Page 123</p>
<p>1 coming in.                  2 Are there any views about that on this? Helen, do                  3 you have any views?                  4 MS CHRISTODOULIDES: Hi, Helen, director of nursing, Leeds                  5 Teaching Hospital Trust. Our volunteers are subject to                  6 the same NHS employment checks as substantive staff.                  7 I have to say, it's done nothing for my volunteer                  8 pipeline, and I'm not suggesting that we amend the                  9 recruitment checks, but the reality is, our volunteers                  10 drop out whilst they are waiting to be processed,                  11 interviewed, DBS checks and so on.                  12 MS KARMY-JONES: Such a long process administratively?                  13 MS CHRISTODOULIDES: It's a long process, and I think the                  14 nature and types of people that volunteer -- Riel, you                  15 said that the WRVS and the ladies or gentlemen pushing                  16 trolleys around wards is very familiar. It is not that                  17 familiar anymore, really.                  18 I get approached by lots of students,                  19 17/18-year-olds, who might want to come and volunteer at                  20 the hospital quickly, before they have to fill out an                  21 application form for university, and, you know, the                  22 people that want to volunteer aren't what you might                  23 imagine typically with the volunteers certainly a long                  24 time ago. So that's my reflection on that. But they                  25 are subject to NHS employment checks, and that does take</p> <p style="text-align: center;">Page 122</p>	<p>1 hasn't committed a crime in the first 40 years of their                  2 life is then going to go on to commit a serious crime in                  3 the next 40 years? We don't know, because people                  4 change, human behaviour changes. I don't quite know how                  5 we actually address this problem.                  6 I am not concerned about the people who aren't                  7 given -- I mean, okay, so we do the DBS checks. It is                  8 not a perfect system. Perhaps we should be doing them                  9 at some sort of regular interval, like every three                  10 years, but what about the people who've never, ever had                  11 them in general practice? Some practices make                  12 a decision that none of our reception staff need these                  13 checks. Well, your reception staff have access to                  14 patient records in most cases. They can look at the                  15 records, they can assess patient vulnerabilities, they                  16 could pass that information on to people who might be                  17 very interested for reasons of their own, for                  18 manipulation or grooming or whatever. I think that we                  19 have a serious gap there.                  20 MS BEAUMONT-WOOD: Can I answer just to that point: it is                  21 not a choice about who chooses to have enhanced or                  22 standard. Actually in law, we can't ask for an enhanced                  23 check for somebody who doesn't fit the criteria. So                  24 I think there is loads of grey area around some of those                  25 roles that may not have everyday contact with children</p> <p style="text-align: center;">Page 124</p>

<p>1 and young people, but may infrequently and wouldn't be                  2 reaching the criteria to have the enhanced check.                  3 MS BRAITHWAITE: Just a couple of issues from me in relation                  4 to this.                  5 The first is, you were asking earlier, what about                  6 all the various other people that go in and out of NHS                  7 establishments, who makes sure that they are okay?                  8 I know that NHS England was certainly concerned about                  9 that issue and so they have been doing work looking at                  10 credentialling and there have been conversations with                  11 the Academy of Healthcare Sciences which is one of                  12 the accredited registers about the possibility of                  13 the academy opening up a credentialling sector for its                  14 register which would potentially offer a route forward                  15 in relation to some of the other occupations that aren't                  16 covered by regulation.                  17 There is the second thing, which is that                  18 professional regulators and, indeed, the accredited                  19 registers -- the professional regulators, they require                  20 that people declare any convictions they have. So                  21 whilst DBS checks might not be repeated again, there is                  22 an ongoing requirement on health professionals to                  23 self-report if they get themselves in trouble in                  24 relation to that.                  25 MS KARMY-JONES: Out of interest, can I just -- do we</p> <p style="text-align: center;">Page 125</p>	<p>1 referred through to them in relation to some --                  2 MS KARMY-JONES: It sounds like there is quite a lot of                  3 reliance on the honesty of the person who is                  4 fulfilling --                  5 MS BRAITHWAITE: Yes, there is.                  6 MS KARMY-JONES: Bearing in mind they may be someone who has                  7 a criminal record, relying on their honesty and                  8 self-reporting may be flawed?                  9 MS BRAITHWAITE: Yes, that is a gap. We flagged it up in                  10 our annual report to parliament this year and the                  11 previous year. It is a gap that needs to be closed.                  12 MS KARMY-JONES: One of the understandings that we have is                  13 that the NHS employers' guidance is that enhanced DBS                  14 checks should be renewed every three years, but that's                  15 only guidance.                  16 MS BRAITHWAITE: Yes.                  17 MS KARMY-JONES: It is not mandatory?                  18 MS BRAITHWAITE: Not that I'm aware of, no.                  19 MS KARMY-JONES: It ties in with what I think Vimal was                  20 saying, that sometimes it is not for 20 years that they                  21 are repeated, if the person being checked is a known                  22 quantity.                  23 Albert, I think you had something you wanted to add.                  24 MR HEANEY: Albert Heaney from the Welsh Government. In                  25 Wales, Welsh local health boards have the responsibility</p> <p style="text-align: center;">Page 127</p>
<p>1 actually know how many actually comply with that                  2 requirement?                  3 MS BRAITHWAITE: I don't have an exact figure, but my                  4 understanding, it tends to be as part of the renewal                  5 process for the regulators. Their processes differ, but                  6 they tend to require it as part of that. Certainly with                  7 the accredited registers, they would require that as                  8 part of the renewal on the accredited registers                  9 programme.                  10 There is a gap, however, which we mentioned in our                  11 formal response to the inquiry here, with regard to                  12 those people who are not regulated by law, they are not                  13 covered by either the Disclosure and Barring Scheme or                  14 by the Rehabilitation of Offenders Act or, indeed, by                  15 the Safeguarding Vulnerables Act. It is an issue that                  16 we flagged up with the Department of Health, who I know                  17 have been in conversations with the Ministry of Justice                  18 and the Home Office to see whether we can close some of                  19 that off. But at the moment, counsellors and                  20 psychotherapists, for example, can't be required by                  21 their registering body to undertake a DBS check or to --                  22 they don't have to declare criminal convictions under                  23 the Rehabilitation of Offenders Act in the same way that                  24 it also causes difficulties for those organisations when                  25 they are trying to investigate any concerns that are</p> <p style="text-align: center;">Page 126</p>	<p>1 for recruitment and checks for staff. You mentioned                  2 guidance, the Welsh Government has issued guidance and                  3 it is clear around the recruitment process and clear                  4 around three-year DBSs. The issue I want to raise is,                  5 I don't think we should be thinking of it as either/or.                  6 This is a whole array of how you create a ring of                  7 safety. So we should be doing DBSs, we should be having                  8 checks that test out, we should be having conversations.                  9 But that's got to be alongside the culture, the                  10 practice, the way we do things around our business, and                  11 it isn't an either/or. I think that's the point I want                  12 to make. It is really important that we get that whole                  13 picture right, and so, therefore, we create the ring of                  14 safety.                  15 You mentioned earlier on about physical premises.                  16 Well, physical premises, certainly we should be going to                  17 those, but we should also be working with local                  18 government partners to think about how we do our                  19 business together and how we are thinking about how we                  20 are reaching out and taking on the challenges. Because                  21 ultimately -- certainly, if you think about adverse                  22 childhood experiences and the experiences that children                  23 and young people have, the only way that we are going to                  24 reach out in a different way to well-being is by, as                  25 partners, working together in a very different focus.</p> <p style="text-align: center;">Page 128</p>

<p>1 I appreciate this is a conversation about, you know,                  2 safeguarding and child sexual abuse, which is the                  3 cornerstone, but I think you have got to build layers on                  4 the way our culture and our approach takes place.                  5 MS KARMY-JONES: Thank you very much.                  6 MS GALLAGHER: Can I follow on from that, which is, I think,                  7 the wider conversation of this afternoon around                  8 governance and accountability, so, again, it is very                  9 interesting what we see from the inspections around                  10 organisations that rely on the structures and the                  11 systems or organisations that own the governance and                  12 accountability themselves. So if there is a feeling                  13 that there are gaps in the governance system, whether it                  14 is the DBS check system or the self-declaration,                  15 different organisations at the moment -- some                  16 organisations we see respond to that very well, and                  17 that's still a conversation about, "So what risk do I,                  18 as a leader in that organisation, think that that poses                  19 for the children and young people in my care and my                  20 ability to keep a focus on their safety and well-being,                  21 and what am I going to do about it?", so it could be                  22 everything from, "I am therefore restricting people's                  23 roles and I am monitoring those restrictions of roles to                  24 lessen their opportunities", and I think, as was just                  25 said, it is about how we join that up to say, "This is</p> <p style="text-align: center;">Page 129</p>	<p>1 you look at the wider story about, how do you get                  2 organisations in general, be it child sex abuse or                  3 anything else, to actually step up to the mark, it's                  4 partly that the leadership is quite strong on the issue,                  5 but it's secondly that you do actually measure and                  6 gather the data in, so you can bring the two to bear on                  7 practice.                  8 I think, you know, the DBS system is quite                  9 complicated to enable that, because, as you say, it is                  10 recommended that it's for three years, but that is for                  11 local discretion in the light of guidance. So you have                  12 got an issue there.                  13 MS KARMY-JONES: Thank you. Just looking at regulation and                  14 the question of setting boundaries of acceptable                  15 behaviour, how should we set boundaries of acceptable                  16 behaviour and how should that be linked to professional                  17 regulation? Anthony, do you have any views on that?                  18 MR OMO: So we currently do set in our guidance the                  19 boundaries we seek between doctors and patients and we                  20 review that periodically, to make sure that is current                  21 and up to date and reflects current practice, working                  22 with the colleges, the public and others. But it is                  23 how, for us, that is then put into practice. That                  24 relies on employers and others, because we can set it                  25 and then, I think, as John said, we see it when things</p> <p style="text-align: center;">Page 131</p>
<p>1 about a system. There are decisions and choices in that                  2 system", but the accountability and the governance                  3 always pointing in the direction of, how is this going                  4 to keep children and young people safe and how is this                  5 going to improve their outcomes. In the best                  6 organisations, you see that seen as a whole manner of                  7 things. In the organisations that are doing less well                  8 with this, it is slightly more of the tick box, "Well,                  9 everybody has had a DBS check and everybody has had                  10 level 2 safeguarding training" and they've done this                  11 tick-box, but they are not asking the question of, "What                  12 difference is this making and am I assured that it is                  13 actually making the difference that I set out to or that                  14 I was told it might make?".                  15 MR VINEALL: Can I make a quick comment? Linking up those                  16 various points, your previous question, which was all                  17 about DBS checks and checking and employment practices                  18 and all those sorts of things, they were all things that                  19 Kate Lampard made recommendations about, lessons learned                  20 after the Savile investigation, and we did a piece of                  21 work with the NHS which kind of, in the typical way,                  22 showed most people were doing most of these things and                  23 the people who weren't were going to pull their socks up                  24 and improve in the light of that report. Okay.                  25 I think the point that Ursula made at the end is, if</p> <p style="text-align: center;">Page 130</p>	<p>1 go badly wrong. In between, there is a whole wealth of                  2 things that happen. That's where I think the employers                  3 and others come to bear and bring their working                  4 practices, shall we say, into play.                  5 So we have got, as I said, a wealth of guidance on                  6 the boundaries, what you should and shouldn't do, how                  7 you should go about doing it, and we review those with                  8 some regularity. But the key is, how it is put into                  9 practice and how doctors put it in. It links to some of                  10 the conversations around the table around cultures,                  11 people being able to speak up, people challenging things                  12 that go against guidance, that people feel are outside,                  13 in the institutions they are in, raising those concerns                  14 and them being dealt with and just linking to the sort                  15 of DBS point. I think it is part of a picture of things                  16 that need to be done, but actually, if nothing happens                  17 when concerns are raised, or nothing happens when nobody                  18 does the check or when soft intelligence becomes                  19 available, then these things go around and people move                  20 from organisation to organisation. So part of                  21 the challenge, I think, and it is employers in the                  22 frontline in the first instance, is the DBS check tells                  23 you one thing, it is a picture, it is a snapshot.                  24 People hear things. You always hear things locally.                  25 What will employers do to respond to that and do they</p> <p style="text-align: center;">Page 132</p>

<p>1 just move the problem on, which is what I tend to see,                  2 we see in our fitness to practise role. When you dig                  3 into it, it's been going on for quite a while. Everyone                  4 is aware of the guidance, they know what the boundaries                  5 are, but no-one challenged and no-one did anything about                  6 it. I think we need to get to the bottom of why that                  7 is.                  8 MS KARMY-JONES: Which will bring us on to whistleblowing                  9 later on as well.                  10 Obviously, the question is relevant to wider                  11 organisations as well, because it is not just the                  12 registered or regulated professions that perhaps need to                  13 deal with this, and the question of who is going to                  14 oversee that and to ensure consistency across the board                  15 is another one that needs to be considered and                  16 addressed.                  17 MR LUCAROTTI: John Lucarotti, Nursing &amp; Midwifery Council.                  18 It strikes me that there are really two groups of                  19 professionals that we are talking about, certainly from                  20 a professional regulation point of view. There are the                  21 ultimate perpetrators and then there are those that                  22 assist in, or lead to the development of the culture                  23 where such -- and things carry on. Of course, our                  24 regulator responses are different in relation to those                  25 two groups. We discuss here the boundaries question,</p> <p style="text-align: center;">Page 133</p>	<p>1 sure that it's actually put in place?                  2 MS KARMY-JONES: We are going to move more and more into the                  3 regulation and accountability side, but it would be --                  4 our aim is to emphasise on how we can work together to                  5 prevent now -- to deal with the prevention of child                  6 sexual abuse in the healthcare setting. What do we                  7 actually do, what do we want to do, about it?                  8 How do the professional regulators have the right                  9 powers and the sanctions at their disposal? Christine,                  10 do you have any observations on that?                  11 MS BRAITHWAITE: Well, the GMC has quite a nice model of                  12 regulation. I think the important thing, thinking about                  13 regulation, is always to put it into its context. It is                  14 one part of the patient safety system and there it can                  15 only ever be one part of the patient safety system, it                  16 can't do more than that. Professional regulation works                  17 by virtue of an individual person signing up to                  18 standards and holding themselves to account and being                  19 responsible for that. So that's the first layer of                  20 protection for the child or for the public, is the                  21 standards that the person follows and adheres to                  22 themselves.                  23 The second level is the employer and the employer                  24 reinforcing the standards and making it possible for                  25 a person to work within those standards.</p> <p style="text-align: center;">Page 135</p>
<p>1 how clear it is. I suspect, in most of the cases that                  2 come before the fitness for practice arena, the                  3 Nursing &amp; Midwifery Council, actually the question for                  4 the people who have perpetrated abuse is not a question                  5 of boundaries, it is self-evidently wrong and there is                  6 no question of ambiguity there, but it is the other                  7 group that more guidance is required for. And of                  8 course, talking about whistleblowing and ability to                  9 speak up in certain circumstances, that's key, that's                  10 a key part of what needs to be out there.                  11 MS KARMY-JONES: So the other group, more guidance is                  12 required for, but who is going to deal with that? How                  13 are we going to deal with it? Do you have any                  14 suggestions?                  15 MR LUCAROTTI: Again, from the NMC's point of view, along                  16 with other regulators, we do have our guidance out                  17 there, we have the code which has already been referred                  18 to today. Indeed, it is quite clear, I suggest, in that                  19 code, what the responsibility of the registrant is                  20 about, you know, the safeguarding issues, prevention of                  21 harm, that sort of thing. But it is a question of how                  22 that is actually implemented into the wider culture, and                  23 I think there are differences of approach, and I suppose                  24 the question that's raised there is, what can the                  25 regulator do in conjunction with the employer to make</p> <p style="text-align: center;">Page 134</p>	<p>1 The third level is the regulator who sets the                  2 standards in the first place for the individual and then                  3 holds those individuals to account for those standards                  4 if they fall apart.                  5 I think what we have said is that there is                  6 tremendous variation between regulators currently                  7 because they were set up at different times, they were                  8 set up under different legislation, they have different                  9 powers. It is difficult to get consistency through that                  10 because of that legislative difference in part, although                  11 there are some things that can be done even in the                  12 absence of legislative reform. But overall, we have                  13 said that there needs to be legislative reform in the                  14 professional regulation field, and we were very hopeful                  15 before the election that we were going to get                  16 a Regulatory Reform Act. We still are hopeful that that                  17 will eventually transpire and we will get that because                  18 we think that the sector is definitely well overdue for                  19 a reform of legislation and that needs to be done.                  20 Some of the examples of that probably -- most                  21 important is the ability for regulators to be able to                  22 apply interim suspension, for example, to people. They                  23 can't currently do that. So if a complaint is made and                  24 you have a concern about somebody, you can't necessarily                  25 put them on interim suspension which is clearly an</p> <p style="text-align: center;">Page 136</p>

1 important power for a regulator to be able to have.  
 2 Sorry, I will stop because I have slightly lost track of  
 3 where I was going.  
 4 MS KARMY-JONES: You were saying, and we were going to make  
 5 the observation, that some statutory regulators are not  
 6 able to impose interim conditions, for example, and the  
 7 standards of sanctions are not the same across the  
 8 bodies and I think you were saying that legislation  
 9 needs to reform, there needs to be legislative reform,  
 10 to pull things into line and to ensure consistency  
 11 across the board.  
 12 As a general point, are powers and sanctions --  
 13 those that are available to regulators, are they being  
 14 used appropriately? Anthony?  
 15 MR OMO: I think we would say yes. I mean, we are  
 16 fortunate, we do have a range of sanctions, we can  
 17 impose interim sanctions, but of course all that depends  
 18 on something surfacing and getting to the regulator.  
 19 What we introduced in 2012 was an employer liaison  
 20 service where GMC senior employees go out and talk to  
 21 responsible officers in Trusts about emerging concerns,  
 22 so things that may be bubbling under or any of  
 23 their doctors that are concerned about. So we have  
 24 early conversations and we are able to advise them on  
 25 what action they might be able to take to protect

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1 patients. These are the low-level cases, before they  
 2 get to us. Obviously, if something surfaces and it is  
 3 about child abuse or something more serious, then that  
 4 comes straight to us, we can impose an interim order and  
 5 stop the doctor from working. So we think we do have --  
 6 one of the things we think is missing, and Christine is  
 7 right, is, in the more serious cases, where someone is  
 8 proven to have assaulted/abused a child and been  
 9 convicted of it, we have to go through a ridiculous  
 10 process of reproofing the conviction so it means they are  
 11 not fit to be a professional. We think we should be  
 12 able to remove them from our register automatically.  
 13 That is something we have been calling for for a while.  
 14 I think the regulation works for us, certainly, in  
 15 terms of doctors, but it is, as such, a level removed  
 16 from the workplace, as it were. As I said, it really  
 17 depends on things surfacing and getting to us. You  
 18 know, we work with the police, as another example, and  
 19 we have an agreement where they will report serious  
 20 crime to us when they are investigating so again we can  
 21 take appropriate action in the interim. But that is  
 22 when it's already happened. We are trying to get --  
 23 I don't like the word -- upstream to try to get at  
 24 things before they become problems.  
 25 One of the things we see is soft intelligence, so,

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1 as I said, you know, we see this time and time again in  
 2 fitness to practise. A doctor who is a concern, has  
 3 been a concern and eventually people say, "Yes, everyone  
 4 knew that". Well, not everyone did. But clearly enough  
 5 people knew and nothing was done about it locally before  
 6 it eventually came to us. There are many, many cases  
 7 like that.  
 8 So we think the service we introduced in 2012 that  
 9 seems to be working well is one part of that. It is  
 10 having those early conversations, empowering responsible  
 11 officers who are senior doctors to have the conversation  
 12 locally, to be able to take action locally and work with  
 13 the regulator on cases that hopefully won't get to us  
 14 because they can be dealt with early enough or are dealt  
 15 with in time and not moved on from organisation to  
 16 organisation.  
 17 MS KARMY-JONES: Thank you. So one of the things that you  
 18 would call for is an automatic removal of licence to  
 19 practise in the event of a conviction for sexual abuse  
 20 against a child?  
 21 MR OMO: Absolutely.  
 22 MS KARMY-JONES: What about the significant proportion of  
 23 those working in the healthcare setting who don't need  
 24 to be registered in order to practise? What about them?  
 25 MR OMO: I think this is where I completely agree with what

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1 Simon said about where the employer kicks in, because,  
 2 ultimately, they are responsible for the people they  
 3 employ to do the job and they need to make sure these  
 4 people are fit to practise. I don't think you need to  
 5 regulate everyone who works in a healthcare setting but  
 6 I certainly think some of the principles of regulation,  
 7 as outlined by Christine, you know, the right person,  
 8 right education, right training, right standards, some  
 9 sort of self-assessment and then the employer having  
 10 supervision and checking arrangements to make sure who  
 11 is there, what they are doing and why they are doing it.  
 12 I think the employer has to take that responsibility  
 13 where they are not regulated.  
 14 MS KARMY-JONES: What about regulating the employer? Who  
 15 checks the checker?  
 16 MR OMO: I'll look that way.  
 17 MS GALLAGHER: Hello, here I am.  
 18 MS KARMY-JONES: Christine. I will come back to you,  
 19 Ursula.  
 20 MS BRAITHWAITE: So those who aren't regulated, I mean,  
 21 I would agree with Anthony that the first port of call  
 22 has to be with the employer. I think there are a couple  
 23 of gaps that need to be filled. One of those is it is  
 24 clearly important that any reference that is given to  
 25 somebody who is moving on from one place of employment

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<p>1 to another is an accurate reference. So that can be an                  2 issue in relation to being able to ensure that anybody                  3 transferring to a new employer is safe and the record is                  4 known.                  5 The second issue is, in relation to the Disclosure                  6 and Barring Scheme, one of the issues that the HCPC                  7 certainly -- sorry, the Health and Care Professions                  8 Council has raised previously is, if they, as                  9 a regulator, make a referral through to the Disclosure                  10 and Barring Scheme, the cases that they think should be                  11 taken up by the DBS are not necessarily taken up. So                  12 roughly a third of the referrals they make they say will                  13 get accepted. Even if they report things as seriously                  14 concerning as sexual abuse, it may not result in the                  15 Disclosure and Barring Scheme taking action. So there                  16 may be a piece of work looking at the threshold, the                  17 Disclosure and Barring Scheme, in relation to that.                  18 With the unregulated staff, those of them who --                  19 I referred earlier to the accredited registers, those of                  20 them who are registered by an accredited register, so                  21 that includes people like counsellors and                  22 psychotherapists, and so on, also healthcare scientists,                  23 who aren't necessarily in a regulated occupation, there                  24 is a whole range of different people. If they are on an                  25 accredited register, then that register will investigate</p> <p style="text-align: center;">Page 141</p>	<p>1 I think one of the things that I would say is                  2 that -- or two things, really. One is the strong need                  3 for overlap between the professional and the system                  4 regulators, because we have often got bits of the story                  5 and it is that classic conversation about how that comes                  6 together. I think the second thing that I would mention                  7 is that, actually, within our regulations, we have                  8 a regulation that requires regulated providers to inform                  9 us of concerns that they have in other people providing                  10 regulated activities. It is something that we are (a)                  11 reminding people of, but (b) starting to take action                  12 under. So I don't have any examples with respect to                  13 child sexual abuse, for example, but where we have had                  14 issues of neglect and abuse in the adult care sector,                  15 saying, "Well, actually, there have been a huge plethora                  16 of community nurses, GPs, all sorts of people, going in                  17 and out of this place who actually have a duty to inform                  18 us of those concerns". I think these are some of                  19 the bits of the regulatory system that we need to join                  20 up and then how we link that in with professional                  21 regulation and responsibility.                  22 I think the point about references is very well                  23 made, and I think it is one -- because one also gets                  24 conflicting advice from employment lawyers about issues                  25 in relation to references, and I'm sure this panel will</p> <p style="text-align: center;">Page 143</p>
<p>1 complaints against them and it will remove them from                  2 their register. It doesn't act the same way as                  3 a statutory regulator in that it is not then an                  4 automatic bar from practising in that occupation.                  5 Somebody could continue to practise as a counsellor or                  6 psychotherapist. So the protection from the accredited                  7 registers programme comes from deliberately choosing                  8 people who are on the accredited register. It's a bit                  9 like a consumer protection scheme. So it is an added                  10 level of protection for patients and the public. It is                  11 also an added level of assurance for employers or                  12 commissioners in terms of, if they are choosing people                  13 from an accredited register, then there is another level                  14 of vetting that is happening and another level of                  15 setting standards and holding people to account for                  16 those standards.                  17 MS KARMY-JONES: Thank you. Ursula?                  18 MS GALLAGHER: In terms of the organisational regulation,                  19 clearly, the vast majority of that sits with us right                  20 across the health and social care system. As you know,                  21 we have just completed in England our national                  22 programme, having inspected the vast majority of                  23 institutions now and conducted over 80,000                  24 organisational inspections in the last three years. We                  25 have put some of the learning in, in our submission.</p> <p style="text-align: center;">Page 142</p>	<p>1 have a great interest in that subject. But also,                  2 a significant proportion of the unregulated workforce                  3 are in some form of line management relationships and                  4 supervisory relationships with the professional                  5 workforce. Those are the things that we look at in                  6 terms of when we go in on inspection about how do those                  7 accountability systems operate; how does -- not only                  8 line management, but clinical and professional                  9 supervision take place; what are the safe spaces within                  10 organisations, and I know we will come on to                  11 whistleblowing later, but I think it is about more than                  12 whistleblowing. It is about, how do organisations                  13 profess that professional and organisational curiosity?                  14 Who is asking the difficult questions? And, in a sense,                  15 who is in charge of thinking the unthinkable, because                  16 part of this has to be about the preparedness to think                  17 that, "It could be going on in my organisation, and how                  18 am I sure that it isn't?". And then to test that out                  19 both in terms of the specific process that we take up                  20 with the executive team, but then we triangulate that in                  21 our local visits. So when we visit a community clinic,                  22 do they say the same thing is happening locally to what                  23 the director manager might say or what the executive                  24 nurse or chief executive might say? So it is that                  25 constant triangulation up and down how the organisation</p> <p style="text-align: center;">Page 144</p>

1 says they are doing it.  
 2 Most of the time -- or quite often in our  
 3 inspections, particularly since safeguarding has been  
 4 a particular issue that comes up when we regulate safe,  
 5 so if you look at our regulation of acute trusts,  
 6 regulation under safe is the most significant area in  
 7 which organisations will have been found to require  
 8 improvement or inadequate. From our perspective, it is  
 9 not simply how well were the systems and processes  
 10 operating, but actually, how well was that demonstrating  
 11 that it was making a difference to all the people within  
 12 the organisation, but in the context of this  
 13 conversation around children and young people, and  
 14 particular concerns, actually, not when children and  
 15 young people are in children's services but actually  
 16 when they are in other parts of the hospital or where  
 17 they are the children or relatives of people that are  
 18 within the system and are you asking those questions  
 19 about children and young people visiting your services  
 20 as well as children and young people being cared for  
 21 within your services.  
 22 MS KARMY-JONES: Thank you. I just want to bring in Kate as  
 23 well here, Health Inspectorate Wales.  
 24 DR CHAMBERLAIN: Kate Chamberlain from the Healthcare  
 25 Inspectorate. We don't regulate the NHS in quite the

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1 same way that CQC does in England. We have done  
 2 a number of governance reviews of health boards where we  
 3 look specifically at how they use what is coming through  
 4 from the concerns system, the complaints system, the  
 5 serious incident reporting, to actually identify  
 6 patterns. I think, in terms of the conversation that we  
 7 have been having, it is quite an important  
 8 identification, preventative tool to be able to look at  
 9 patterns of what might be quite small issues that are  
 10 bubbling up in order to be able to identify where there  
 11 might be an issue with either a service or an  
 12 environment or an individual.  
 13 But I think, going back to what was said about soft  
 14 intelligence, soft intelligence is incredibly important.  
 15 You need to get people to report and to raise concerns  
 16 at, I think, possibly a lower level than we do at the  
 17 moment. Whistleblowing, as a term, I don't think is  
 18 particularly helpful. It almost feels like you have to  
 19 have a lot of courage to do it. Also, when you start  
 20 talking about raising concerns, maybe raising concerns  
 21 about the practice of colleagues, again, it feels  
 22 a little bit confrontational. Whereas, actually, it is  
 23 in everybody's interests that we are raising concerns,  
 24 actually, if we focus on the individual, about whether  
 25 that individual is having their risk managed properly,

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1 is safe and, quite often, raising an issue with  
 2 a colleague about the way in which they are behaving  
 3 could be presented as protecting them as well. You  
 4 wouldn't want to be seen to be operating in a way which  
 5 is not in accordance with policies and procedures, it  
 6 could be risk review, you need to help look after  
 7 yourself. So I think language in this context as well  
 8 is really important and that needs to flow down through  
 9 the education and training.  
 10 Because soft intelligence and pattern spotting  
 11 doesn't work unless you have the data coming up to you  
 12 in the first place.  
 13 MS KARMY-JONES: Thank you very much. I'm just conscious of  
 14 the time, and I need to go to the public gallery, but  
 15 I will come back to you after the break, if I may.  
 16 Is there anyone in the public gallery who would like  
 17 to make an observation? Mr O'Mara?  
 18 Observations from the public gallery  
 19 MR O'MARA: Nigel O'Mara, East Midlands Survivors. I just  
 20 wanted to get a couple of very small clarifications.  
 21 Ms Gallagher, earlier on, when you were speaking  
 22 about the adult wards and you said that very small  
 23 numbers of children were being put into these adult ward  
 24 situations, is there any way of us finding out what that  
 25 actual number is on that?

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1 MS GALLAGHER: I think there is some data that's been  
 2 available and that has been shared. I think I would  
 3 want it to be clear that we need to tackle even very  
 4 small numbers, because it is not the right thing at all.  
 5 I think what I did say is that one of the difficulties  
 6 in planning services is that children across the country  
 7 present with very niche and particular needs that we  
 8 need to be able to meet in terms of how it is that we  
 9 develop targeted services, and that's why sometimes we  
 10 need to plan at populations greater than the local area.  
 11 MR O'MARA: Also, Mr Omo, you said that you had some  
 12 policies in place around boundaries, et cetera. Are  
 13 those policies publicly available?  
 14 MR OMO: Yes, they are.  
 15 MR O'MARA: Lovely. Thank you. Where would they be  
 16 accessed?  
 17 MR OMO: On our website.  
 18 MS KARMY-JONES: Mr Omo is for the General Medical Council.  
 19 If you look, the General Medical Council website  
 20 actually contains a huge amount of guidance and policy  
 21 data, including details of individuals, I think, that  
 22 you can even do checks on, on the website. It is very  
 23 well filled out.  
 24 MR OMO: Yes.  
 25 MS TUCK: Just quickly, other VSCP members who are watching

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1 the live stream have two questions. Sheila Coates:  
 2 "How well are health staff trained to understand the  
 3 vulnerability of girls, including BME girls, on  
 4 mixed-sex, adult mental health wards? How is this  
 5 vulnerability risk assessed and mitigated?"  
 6 Second question:  
 7 "What processes are in place for children to be able  
 8 to access an independent advocate when they are resident  
 9 in a healthcare setting?"  
 10 MS KARMY-JONES: Thank you for those. We will reflect on  
 11 those over the break, if that is all right, and come  
 12 back on that.  
 13 Chair, is that an appropriate moment?  
 14 THE CHAIR: Yes, thank you. We will return at 3.15 pm.  
 15 (3.00 pm)  
 16 (A short break)  
 17 (3.15 pm)  
 18 MS KARMY-JONES: Can I just touch on something? I think,  
 19 Mr O'Mara, you were asking about data and where it can  
 20 be found, so I just thought I would tell you where we  
 21 found our little piece of information that we gave  
 22 earlier about there being 391 children in 2014 and 2015  
 23 who were treated in adult mental health wards. That  
 24 came from a Freedom of Information request from  
 25 The Guardian, of NHS Digital, who don't, we understand,

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1 routinely publish. It is from a Guardian publication.  
 2 But as far as we are aware, NHS Digital don't routinely  
 3 publish data.  
 4 MR O'MARA: Thank you.  
 5 MS KARMY-JONES: If that helps. Some of the other questions  
 6 that have been raised we will touch on tomorrow when we  
 7 come to culture and leadership.  
 8 Discussion re Topic 2 (continued)  
 9 MS KARMY-JONES: Now I want to turn, first of all, please,  
 10 to William, because you had something you wanted to  
 11 raise before the break.  
 12 MR VINEALL: Two quick things: one for the record, that the  
 13 government is considering options about how to progress  
 14 the reform of professional regulation and I think the  
 15 analysis that the others gave of what the issues are is  
 16 a very reasonable one.  
 17 The only contrast I was going to then make was the  
 18 comments that Ursula made, that that, in a sense, is the  
 19 pinnacle of the response and, actually, a lot of things  
 20 can be gathered by more local activity on the ground,  
 21 which I know is something you are going to come on to.  
 22 MS KARMY-JONES: Thank you very much. The next topic, then,  
 23 that we want to move on to is the legislative framework  
 24 and the roles and responsibilities within that.  
 25 The question, really, that we have is: how well do

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1 you consider the legislative framework and the current  
 2 roles and responsibilities within the health sector  
 3 support the effective prevention of child sexual abuse  
 4 in healthcare settings? Perhaps we could start out with  
 5 NHS England and see what your views are on that?  
 6 MS WARBURTON: I think we have got a range of frameworks  
 7 that we use, particularly within NHS England. We have  
 8 got our own framework, the safeguarding accountability  
 9 and assurance framework, which sets out quite clearly  
 10 our expectation of the health sector, including  
 11 ourselves as a commissioner and system leader. We use  
 12 a variety of other policies. We have talked about the  
 13 competencies frameworks and the other sort of frameworks  
 14 we use around legislation, things like the Care Act and  
 15 some of the requirements on us in the Care Act, the  
 16 Children Acts and of course, most recently, the Children  
 17 and Social Work Act, which is about to reform a lot of  
 18 what we do around children safeguarding. It might be  
 19 worth perhaps drifting into that, because there are some  
 20 concerns around the potential for such localisation  
 21 within that reform that we could lose some of  
 22 the outcomes that we are trying to achieve.  
 23 MS KARMY-JONES: Thank you. William, do you have anything  
 24 to say on this point?  
 25 MR VINEALL: I was only going to say that obviously from the

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1 government's point of view there needed to be some  
 2 changes because we passed the legislation that came into  
 3 force at the end of April with a view that the changes  
 4 that would be made would put, I suppose, an additional  
 5 impetus on the police, social care and the health system  
 6 to form up together locally to look at these significant  
 7 issues, and the feeling that the previous arrangements  
 8 that we had weren't always as thorough as they might  
 9 have been. Now, that hasn't been implemented yet, but  
 10 clearly the government's position is, there is room for  
 11 improvement, or we wouldn't have changed the  
 12 legislation.  
 13 MS KARMY-JONES: Can I bring in NHS Wales on that, please?  
 14 MR HEANEY: Albert Heaney. There has been a range of  
 15 legislation changes taking place in the Welsh context.  
 16 The first one to cite, really, is the Social Services  
 17 and Well-being (Wales) Act. Sometimes criticised  
 18 because it is called Social Services and Well-being  
 19 (Wales) Act and doesn't reference the other agencies,  
 20 but the duties placed upon it do fall to other partners.  
 21 The first thing to say is around safeguarding. One  
 22 of the gentlemen from the public gallery raised about  
 23 taking notes during potential disclosures. The Act  
 24 actually puts a formal duty on the professionals  
 25 involved in children's safeguarding and child work to

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<p>1 formally report that concern through, so it goes further 2 than note taking into duties placed upon. 3 MS KARMY-JONES: Have you done a comparison between the 4 English legislation and the Welsh legislation? 5 MR HEANEY: Yes, of course we have looked, and when we were 6 going through the legislation journey, the Act was 7 passed in 2014, implemented in 2016, we had a lot of 8 discussions across border, discussions, as you would 9 appreciate. There were some differences. 10 There were some issues that we also had to work 11 through during the passing of the legislation about 12 devolved and non-devolved legislation, there are 13 competencies, and of course that is another added issue 14 in terms of the considerations that need to take place, 15 because there are non-devolved organisations involved in 16 child protection, such as the police, probation, 17 et cetera. 18 One part of the Act which I wanted to reference, 19 because I think it is important when we are thinking 20 about solutions and how we do things differently, the 21 Act is about well-being. I have mentioned some of 22 the duties and strengthening around safeguarding but 23 also well-being duties are placed -- duties upon the 24 health and social care, housing and third sector 25 partners to formally come together in regional</p> <p style="text-align: center;">Page 153</p>	<p>1 over the last few years. About seven years ago now, we 2 began looking to see how effective professional 3 regulation actually was in terms of impacting on 4 people's behaviour, and both we and the regulators have 5 been undertaking various research projects in relation 6 to that. 7 I think what's become very clear to us is that it is 8 very hard now to separate the regulation people from the 9 regulation of places, because people work in places and 10 they are affected by the environments in which they 11 provide care. I think we have heard numerous examples 12 today, as we have been going through, about the 13 importance of workplace environments in terms of trying 14 to prevent opportunities for sexual abuse taking place. 15 So I think we would say now, if we were all starting 16 with a blank sheet of paper, we probably wouldn't 17 separate out the regulation of people from the 18 regulation of places. That said, we clearly have a vast 19 amount of legislation and I'm not imagining we would 20 just do away with it all now, but I do think that there 21 is merit in looking at the connection between 22 professional regulation and system regulation and 23 thinking about how those things can be coordinated and 24 carried out in a way. That means emphasis being put on 25 professionals being provided with a workplace</p> <p style="text-align: center;">Page 155</p>
<p>1 partnership boards to plan together completing 2 population assessments and introducing joint area plans. 3 What's interesting about the scale of that, it's been 4 based on a regional footprint that's aligned to our 5 local health boards, so we capture the issues across 6 that particular front and footprint. There is other 7 legislation but, without going into all that, I know we 8 can share some of that. There is a whole lot of work 9 taking place around the Regulation and Inspection of 10 Social Care (Wales) Act and other legislation around the 11 healthcare as well. 12 MS KARMY-JONES: William, presumably, we have here looked at 13 what is going on in Wales and drawn some comparisons 14 with it? 15 MR VINEALL: I wasn't close to the piece of work, so I can't 16 answer that question, I'm afraid, but I can come back to 17 you. 18 MS KARMY-JONES: Thank you very much. Does the way the 19 system is organised effectively prevent child sexual 20 abuse and account for effective prevention? Does anyone 21 have any observations on how the system is currently 22 organised? Christine? 23 MS BRAITHWAITE: Christine Braithwaite, Professional 24 Standards Authority. I think we would offer one 25 observation that we have increasingly become aware of</p> <p style="text-align: center;">Page 154</p>	<p>1 environment that is supportive of them carrying out 2 their responsibilities properly and effectively towards 3 patients. 4 MS KARMY-JONES: In England, we have heard, and this has 5 been part of some of the responses, that the greater 6 decentralisation of the NHS structure is leading to 7 a greater variety in local practices, so what impact has 8 that had on prevention of abuse within healthcare 9 settings? Ursula? 10 MS GALLAGHER: I think from our work, establishing simple 11 cause and effect is actually quite difficult to do in 12 what we have already highlighted is quite a complex 13 system. So actually in some areas, as I said earlier, 14 the variation actually means that the way they have 15 implemented things locally is really good and is really 16 working effectively to prevent child sexual abuse. In 17 other areas, ostensibly working under the same 18 legislative framework but taking their own local 19 interpretation, it is not working quite so well. So 20 I think there is always that slight concern about, you 21 know, a legislative Holy Grail that would be the answer 22 to all of this, and it comes back to some of those 23 things that we have referenced already. 24 Certainly, in our own child exploitation report 25 "Time to Listen", you will, I am sure, recall that we</p> <p style="text-align: center;">Page 156</p>

<p>1 did see some really, really effective practice working 2 within the legislative frameworks, but it was about 3 a group of leaders coming together to use that framework 4 to its best.</p> <p>5 I think that that is a real reflection and challenge 6 for us, which is about how, in an area like this, do we 7 assess that degree of variation and, again, for us, it 8 is about continuing to focus on the issues about how the 9 outcomes are measured and assessed more than it is 10 getting into the minutiae about how people tick-box all 11 the issues around the systems and the processes.</p> <p>12 I think one of the areas that we also regulate and 13 is worth referencing here is actually the independent 14 health sector, so, again, most of the colleagues around 15 the table are from the NHS, but actually there are a lot 16 of -- significant numbers of vulnerable children and 17 young people and there are also children and young 18 people in circumstances we know already make them 19 vulnerable, in circumstances such as domestic abuse and 20 violence or children who are already in the "children 21 looked after" system, and, again, I think we see there 22 considerable variation in practice and sometimes 23 considerable disagreement about what best practice looks 24 like and, again, I think some of the challenges are 25 about -- I say clinical in the broadest sense of</p> <p style="text-align: center;">Page 157</p>	<p>1 I think it is certainly the landscape is much more 2 complex than it was 15/20 years ago, both in terms of 3 what's commissioned in terms of child healthcare 4 services, and also the plethora of providers that we now 5 have. But that's not necessarily a bad thing. So for 6 children and young people and their families, it can 7 actually mean greater choice, it can mean access closer 8 to home, it can mean provision of innovative services.</p> <p>9 So I think when we use the term -- I understand you 10 have used it in inverted commas, as it were, 11 "fragmentation" -- it can bring good things. But 12 I think what it has done is brought complexity to the 13 system. I think what we have heard today is, actually, 14 we can look at individual silos, so we can look at 15 Trust A, we can look at GP surgery Y, et cetera, and 16 that's important, and we have heard from three 17 colleagues why that's important, but actually we need to 18 look at how this works across the local system. The 19 work that William described earlier and the government's 20 proposals around revising working together to provide 21 greater impetus and a role for the local system, the 22 tripartite system, to address that is really important.</p> <p>23 I think the other issues, just around prevention, 24 I think clearly it hasn't worked because we still have 25 far too many cases of children being abused in</p> <p style="text-align: center;">Page 159</p>
<p>1 the word, but actually, the clinical evidence base 2 around what works and the extent to which a culture of, 3 if we haven't invented it here, it won't be right, as 4 opposed to cultures that are very open and porous to 5 bringing in new ideas and challenging them themselves 6 and keeping that focus on, are we sure we are doing the 7 best by our children and young people in terms of 8 prevention.</p> <p>9 As I said earlier, the areas that do really well are 10 the areas who constantly challenge themselves. If their 11 numbers are low, they don't make the assumption that 12 that's because they're really good at preventing it. 13 They first ask the question, "Are we really good at 14 detecting it?", and it is that constant challenge that 15 says, actually, zero might not be a reassurance, and 16 that's what those -- when you hear -- when you talk to 17 those leaders, that's what you hear them talking about.</p> <p>18 MS KARMY-JONES: Thank you. Eustace, can I bring you in on 19 this and just ask you your views on whether the 20 fragmentation, for want of a better word, of 21 the healthcare system in England means at times -- first 22 of all, what impact has it had on the prevent of abuse 23 within healthcare settings and does it at times mean 24 accountability is unclear? What's your view? 25 MR DE SOUSA: Eustace de Sousa, Public Health England.</p> <p style="text-align: center;">Page 158</p>	<p>1 healthcare settings and other settings.</p> <p>2 From a public health point of view, I'm sure my 3 other colleague will bear this out, actually healthcare 4 settings -- we have tended to talk today about very 5 classical buildings, if you like, a hospital or a GP 6 surgery. From a public health point of view, the 7 healthcare setting is anywhere where healthcare is 8 provided. So that could be on the street corner through 9 street-based work, it could be in a school as well.</p> <p>10 I think we need to make sure we are broadening our 11 overview of this so that it is inclusive of those other 12 settings.</p> <p>13 I think we have also got, because of that, a great 14 deal to learn from social care around this as well, both 15 in terms of the oversight, expectations of staff and 16 setting a culture. I'm not saying social care is 17 perfect, but clearly they have a great deal of 18 experience in this particular area.</p> <p>19 MS KARMY-JONES: Thank you very much. Susan, do you have 20 anything to add to that about the fragmentation of 21 the system and its effect on accountability and child 22 protection as a whole? 23 MS WARBURTON: I think it seems a quite a lot more complex 24 for our commissioners when they are trying to monitor 25 a range of healthcare settings with different providers,</p> <p style="text-align: center;">Page 160</p>

1 with different service certifications and it's put  
 2 a complexity in there, which they're now grappling with.  
 3 There is a fragmentation, I agree with you, but it  
 4 brings a lot of opportunities as well and we have seen  
 5 some really good examples of children's care and good  
 6 outcomes coming out of that change, but it has created  
 7 challenges. I think when you start to think about your  
 8 Clinical Commissioning Groups, it is about the expertise  
 9 within those groups, and some of you will be aware that  
 10 some Clinical Commissioning Groups are now coming  
 11 together to collaborate on commissioning and hopefully  
 12 get some of the expertise back in the system that we  
 13 perhaps lost for a while with the smaller CCG groups.  
 14 MS KARMY-JONES: Thank you. Yes, Angela?  
 15 MS HORSLEY: Angela Horsley, NHS Improvement. I suppose the  
 16 other, I suppose, opportunity is the fact that there are  
 17 joint regional chief nurse posts now between NHS England  
 18 and NHS Improvement. So I think that enables, you know,  
 19 improved communication, especially when sort of like  
 20 dealing with the different provider trusts.  
 21 MS KARMY-JONES: William, is there something you wanted to  
 22 add to this?  
 23 MR VINEALL: I was only going to say the new Act, the  
 24 Children and Social Work Act 2017, does explicitly give  
 25 greater flexibility for local areas to determine how

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1 they arrange services to safeguard children. So  
 2 I wouldn't characterise that as fragmentation -- I know  
 3 the point that you are making -- that is the reason why  
 4 you have to have a strong regulator, to inspect these  
 5 things. It is also the reason why, if you give people  
 6 local flexibility, you need strong boards that are  
 7 accountable, have a good grasp of data and can actually  
 8 justify what data means without the number being lower,  
 9 meaning necessarily you don't have a problem. There is  
 10 a whole range of work in this area and others about  
 11 encouraging open reporting of events, be they child sex  
 12 abuse or other things, because that gives you a picture  
 13 of what the issues actually are.  
 14 MS KARMY-JONES: If the data is collated and disclosed.  
 15 MR VINEALL: Yes, if the data is collated and disclosed and  
 16 if you have the right leadership at the board level, the  
 17 two together can be quite powerful for addressing  
 18 issues, but you need both of those. I don't think  
 19 having local flexibility then to resolve problems is  
 20 necessarily a bad thing.  
 21 MS KARMY-JONES: One of the issues we found this morning was  
 22 that there may be an issue around data and its  
 23 availability. Would you agree with that? Are you aware  
 24 of that?  
 25 MR VINEALL: I don't know. I shouldn't think data is

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1 consistent.  
 2 MS KARMY-JONES: I'm just going to ask, Vimal, actually, if  
 3 you have anything to add to this?  
 4 DR TIWARI: I think, as general practitioners, we find it  
 5 all very difficult because the system changes have  
 6 resulted in a couple of years of uncertainty during  
 7 which time the pressures on general practitioners have  
 8 increased. Even now, there are changes again with the  
 9 Clinical Commissioning Groups going to -- there is  
 10 delegated commissioning and taking over responsibility  
 11 for commissioning services. The difficulties lie, as  
 12 I think someone rightly said, in the level of expertise  
 13 within these commissioning groups, and how well they  
 14 understand the services they are commissioning and,  
 15 therefore, to what standard they can be monitored  
 16 effectively. What does "good" look like if you are  
 17 a commissioner without the experience of running  
 18 a particular service?  
 19 MS KARMY-JONES: Thank you. Clarisser?  
 20 MS CUPID: Someone mentioned about a fragmentation of  
 21 the NHS and the challenge around, you know, safeguarding  
 22 arrangements across the different providers, so to  
 23 speak. Now, within each borough, within each locality,  
 24 there should be a designated professional that takes on  
 25 that responsibility for ensuring that safeguarding

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1 across all health -- the whole health economy, whether  
 2 commissioned or not commissioned by the CCG, have  
 3 a sound approach, so to speak, and is compliant with  
 4 safeguarding arrangements.  
 5 The designated function, and that could be the  
 6 designated nurse or doctor, would link up via the  
 7 safeguarding board to ensure that provider services,  
 8 whether they are commissioned by the CCG or by local  
 9 authority or -- is a voluntary agency at all, they would  
 10 ensure that safeguarding arrangements are up to the  
 11 standard that's required.  
 12 I just wanted to ensure that we have that in  
 13 consideration when we make our recommendations.  
 14 MS KARMY-JONES: Several of the submissions that we received  
 15 noted that there is no specific mention of healthcare  
 16 services in child protection legislation. Does that  
 17 have an impact on how well the law works to prevent  
 18 abuse within those settings? Can I ask you, Anthony?  
 19 Do you have a view on that?  
 20 MR OMO: Not really one for me, but I don't think it is  
 21 necessarily about what's written into the legislation,  
 22 because it is a last -- it is a sort of last defence  
 23 rather than a first defence. I think it is more about  
 24 the intent and how -- as I think Clarisser has just  
 25 said, people in place to actually put it into practice.

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<p>1 The question I had when Clarisser was speaking was, is                  2 a single person sufficient to actually carry out that                  3 function, given the breadth in some of these areas? But                  4 I can defer to others on what the legislation says or                  5 doesn't say.                  6 MS BEAUMONT-WOOD: Can I just offer an observation? While                  7 I think we will always need people in a specific                  8 dedicated leadership role, such as designated doctors,                  9 nurses, et cetera, it can also be our weakest link,                  10 because, actually, the point that's been made several                  11 times is, it is everybody's business. If it is seen to                  12 be the job of somebody "over there", that sort of                  13 diminishes the ownership of an individual health                  14 professional in its broadest context. We will need it                  15 to provide leadership and work on things, but I think we                  16 need to be careful that it is not instead of, it is to                  17 complement and support the workforce per se.                  18 MS KARMY-JONES: Thank you. Vimal?                  19 DR TIWARI: Yes, Vimal Tiwari from the Royal College of                  20 General Practitioners. Just to come back to the                  21 important point about the duties of the designated team,                  22 what happened immediately after the Health and Social                  23 Care Act was that commissioning went in two directions.                  24 So primary care was commissioned by NHS England, whereas                  25 secondary care and tertiary care and community care were</p> <p style="text-align: center;">Page 165</p>	<p>1 previously, we can start to embed some of that learning                  2 into children's services going forward and the                  3 collaboration that we are doing with local authorities                  4 and Public Health England and others to actually build                  5 services that are fit for purpose going forward, I think                  6 will actually help rather than hinder us. I think there                  7 is a unique opportunity, but we have really got to learn                  8 the lessons that we are being faced with. Some of                  9 the things we have been talking about today can actually                  10 be embedded in some of those new models of care.                  11 MS KARMY-JONES: Thank you. Angela, do you have a view on                  12 that?                  13 MS HORSLEY: Angela Horsley, NHS Improvement. I am sitting                  14 here, obviously, from NHS Improvement and I'm also                  15 sitting here as a senior children's nurse by background                  16 as well. I think there is something about children on                  17 the agenda and I think when you are looking at the                  18 five-year forward view, it is not just to take that                  19 literally, it is to ensure that there is a consideration                  20 for all those work streams to put children there in                  21 actual fact, and, as you are putting children there, you                  22 are also thinking about the unthinkable and where does                  23 safeguarding, in its broadest term, fit into all of that                  24 as well.                  25 MS KARMY-JONES: Thank you. Helen, what about you?</p> <p style="text-align: center;">Page 167</p>
<p>1 commissioned by the CCGs.                  2 The designated -- the guidance at that time was that                  3 the designated team had a responsibility towards the                  4 CCGs, which left primary care under the care of                  5 NHS England. So there was a difference. There was                  6 a difference in the way the services were monitored and                  7 in the way standards were applied depending on locality.                  8 It is changing again because of delegated commissioning,                  9 and, really, I think things are becoming much more                  10 straightforward and much easier for primary care                  11 providers to understand.                  12 MS KARMY-JONES: Thank you. In England, what opportunities                  13 do plans under NHS England's five-year forward view, for                  14 example, the implementation of new models of care and                  15 sustainability and transformation plans, what                  16 opportunities does that create for the way that services                  17 protect children from abuse?                  18 MS WARBURTON: Susan Warburton, NHS England. I think the                  19 five-year forward view actually gives a wealth of                  20 opportunity to reshape services for children, young                  21 people and protection of those children within those                  22 services. We have got a unique opportunity. It is                  23 a once in a lifetime, probably, opportunity to get it                  24 right. Because of the work that we are doing and have                  25 learned from some of the investigations that have gone</p> <p style="text-align: center;">Page 166</p>	<p>1 MS CHRISTODOULIDES: Riel, I'm so glad you mentioned it.                  2 I thought everyone had forgotten about the five-year                  3 forward view and the opportunities that surely will                  4 arise from local STPs. As I sit here thinking about the                  5 work streams and what opportunity might we exploit,                  6 I think, as much as the physical changes, it is learning                  7 to work together with partner organisations, building                  8 trust, and there has been a barrier in the NHS, I think.                  9 So I think that those cultural changes, learning to                  10 operate with adult social care colleagues as a nurse by                  11 background, someone that's worked in the NHS, is                  12 valuable for me, and vice versa, and I think those                  13 relationships that will emerge are as important as the                  14 structural changes we make for services. That would be                  15 my comment.                  16 MS WARBURTON: I think I just wanted to add, really, that                  17 some of the new service models that are being looked at                  18 across the country are in co-production with children                  19 and young people, and actually we are starting to hear                  20 their views about what they would value in a service                  21 delivery for them, which is something that maybe we                  22 haven't done particularly well previously, but it is                  23 certainly an opportunity we have now.                  24 MS KARMY-JONES: It ties in very much with one of                  25 the questions we had from the public gallery, which was,</p> <p style="text-align: center;">Page 168</p>

<p>1 how much account is being taken and how much                  2 collaboration is there with the victims and survivors of                  3 this kind of offending and this kind of abuse. Is there                  4 a great deal of collaboration?                  5 MS WARBURTON: There is. At the moment, I am involved in                  6 some work in NHS England around developing and making                  7 a framework for commissioning sexual abuse services                  8 where there's been an enormous amount of collaboration                  9 with survivors. Many workshops, they have been involved                  10 in every part of the structure of that commissioning                  11 framework, and that's added such an enormous value in                  12 the actual context in which we are building the                  13 commissioning for the future. But they've been from the                  14 ground up, really, in building the essence of it..                  15 MS KARMY-JONES: Thank you.                  16 Eustace, did you have something that you could add                  17 to this?                  18 MR DE SOUSA: Eustace de Sousa from Public Health England.                  19 Just to endorse the couple of comments that have just                  20 been made in particular by Sue. I think the five-year                  21 forward view offers us a really exciting opportunity to                  22 really shift the way in which services are provided and                  23 delivered to children, young people and their families.                  24 I think there are a couple of challenges. There is                  25 obviously the challenge about resources and competing</p> <p style="text-align: center;">Page 169</p>	<p>1 There is quite a strong accountability back to                  2 NHS England, and it does allow you to have more                  3 population-wide services. So for all the things we are                  4 talking about here, they are advantageous.                  5 MS KARMY-JONES: Thank you.                  6 I would just like to tie things up with a question,                  7 and, really, I would like as many answers as possible to                  8 this, and as many different views: what changes would                  9 have the biggest impact to ensure that roles and                  10 responsibilities for the prevention of child sexual                  11 abuse are clear, stringent and effectively enforced?                  12 What would you recommend? Let's start with you,                  13 Anthony?                  14 MR OMO: I think following, discussions this morning and                  15 this afternoon, I would say a consistent approach to                  16 education and standards across regulated and                  17 non-regulated staff in the health setting, so everyone                  18 is clear about what is required of them and there's                  19 accountability there.                  20 The other point I would make is: some sort of                  21 education or information programme for patients so they                  22 understand what to expect, and/or their carers or                  23 families, so when they go into these settings they know                  24 what is normal and what is not normal and they can deal                  25 with it themselves.</p> <p style="text-align: center;">Page 171</p>
<p>1 demands. I think there is a challenge around, sometimes                  2 in some areas children might not be as visible as they                  3 are in others. Ursula has already advised us of that                  4 variability.                  5 I think there is an issue around how we, as system                  6 leaders, help to galvanise the best to come to the                  7 surface for all the other areas as well.                  8 I think the other point to raise, which kind of                  9 links to the point that we were talking about earlier                  10 about fragmentation, is, the local systems haven't stood                  11 still. Because of the fragmentation, as you described                  12 it, in most areas now they are moving towards integrated                  13 commissioning and service delivery, and that is as                  14 a direct response to some of the challenges that we                  15 heard earlier.                  16 I think it is really important to bear that in mind.                  17 Again, it is not to be complacent, but it is to                  18 recognise that actually, at a local level, generally                  19 they understand some of these challenges and they are                  20 looking at ways in which they can resolve that within                  21 the current legislation.                  22 MS KARMY-JONES: Thank you very much.                  23 William?                  24 MR VINEALL: Yes, STP. They allow local organisations to                  25 plan beyond a single institution, which is an advantage.</p> <p style="text-align: center;">Page 170</p>	<p>1 MS KARMY-JONES: Thank you. Albert, do you have any                  2 observations on this?                  3 I would like to go around, actually, and see if                  4 everyone can contribute something.                  5 MR HEANEY: Thank you very much. Two points, then. First                  6 one is, I think, related to training and development                  7 being across partnership organisations so that you use                  8 the learning. There have been many inquiries held over                  9 many years, and the learning is cross-referenced if we                  10 look for it.                  11 The second one is a bit of a curve ball, but                  12 Coventry University, there was research certainly                  13 recently that showed quite a correlation between                  14 deprivation and the outcomes for children around child                  15 sexual abuse. I think that is something we have to look                  16 at in more detail and consider how we can look at the                  17 future together.                  18 MS KARMY-JONES: We are going to come on to particularly                  19 vulnerable individuals tomorrow and how that's addressed                  20 in the learning curve.                  21 Christine?                  22 MS BRAITHWAITE: Thank you. I think mine would be an                  23 emphasis on practising constructive mistrust, so that is                  24 as part of education and training but also within the                  25 workplace and having a proper support mechanism in place</p> <p style="text-align: center;">Page 172</p>

<p>1 for people to be able to do that.</p> <p>2 MS KARMY-JONES: Eustace?</p> <p>3 MR DE SOUSA: I think just to incorporate the points from my</p> <p>4 two previous colleagues, really. So not a single</p> <p>5 a solution, I don't think it is as straightforward as</p> <p>6 that.</p> <p>7 Clearly, we need a competent workforce that's able</p> <p>8 to -- around professional curiosity and challenge. You</p> <p>9 heard that earlier in the session this morning.</p> <p>10 We need to make sure we have an informed and</p> <p>11 confident public, patient, who understands what they can</p> <p>12 expect from a particular health interaction and what</p> <p>13 their rights are. So it is more of a rights-based</p> <p>14 approach, particularly when we are talking about</p> <p>15 children and young people because you are often</p> <p>16 involving their carers as well, depending on the age of</p> <p>17 the child.</p> <p>18 We clearly need strong regulation and</p> <p>19 accountability.</p> <p>20 But I think all of that is wrapped up around</p> <p>21 a culture of how we see children, how society sees</p> <p>22 children, and how we deem what is acceptable in terms of</p> <p>23 their treatment. So I think a kind of culture would</p> <p>24 oversee that, and I know that's the subject of your</p> <p>25 session tomorrow.</p> <p style="text-align: center;">Page 173</p>	<p>1 NHS Improvement is a relatively new body of Monitor and</p> <p>2 the TDA coming in together, and I think when it comes to</p> <p>3 safeguarding and CSA, it is very much in its infancy at</p> <p>4 the moment.</p> <p>5 MS KARMY-JONES: How can that be done?</p> <p>6 MS HORSLEY: I could get together with the regional chief</p> <p>7 nurses, and also Susan as well. We have already made</p> <p>8 some of those arrangements.</p> <p>9 MS KARMY-JONES: Good. Excellent. Ursula?</p> <p>10 MS GALLAGHER: It certainly is the \$24,000 question, isn't</p> <p>11 it, this one. I would echo what people have said.</p> <p>12 All organisations that are registered with us begin</p> <p>13 by giving us their statement of purpose. If you</p> <p>14 actually look at those statements of purpose -- there</p> <p>15 can't be a list of every single subpatient group that</p> <p>16 they might be going to serve, but actually children and</p> <p>17 young people are very rarely mentioned in them</p> <p>18 specifically and some of those issues around outcomes,</p> <p>19 how do we see that change in focus, particularly as</p> <p>20 these new care models come along?</p> <p>21 What are then the measures and rewards that the</p> <p>22 wider system thinks about putting into place, and</p> <p>23 aligning some of those incentives; you know, as we come</p> <p>24 into winter, and what it is that the system thinks it</p> <p>25 has to prioritise at the moment. These are the moments,</p> <p style="text-align: center;">Page 175</p>
<p>1 MS KARMY-JONES: We will come back to that tomorrow, but it</p> <p>2 is helpful to get those views so we can refine what we</p> <p>3 are going to ask tomorrow. So thank you.</p> <p>4 Susan?</p> <p>5 MS WARBURTON: I think, for me, it is very much around the</p> <p>6 undergraduate education, and actually embedding it at</p> <p>7 the beginning of professional training and education.</p> <p>8 But also, picking up, as we did this morning, that</p> <p>9 broader sense of what is acceptable, what should we be</p> <p>10 accepting, as a population; do we know what's right and</p> <p>11 what's wrong? And particularly around when we talk</p> <p>12 about chaperoning and chaperones, and that almost</p> <p>13 professional role that perhaps needs to be developed</p> <p>14 around that and not the passive "I will stand there and</p> <p>15 do my emails while I'm waiting" type of approach.</p> <p>16 So I think there are a few things, but it all comes</p> <p>17 down to accountability.</p> <p>18 MS KARMY-JONES: Thank you.</p> <p>19 Angela?</p> <p>20 MS HORSLEY: For me, it is about raising the profile of</p> <p>21 children and young people and really recognising their</p> <p>22 needs from a safeguarding point of view. And then, from</p> <p>23 an NHS Improvement point of view as well, it is really</p> <p>24 getting together with NHS England and really working out</p> <p>25 who is doing what, because, as I said earlier,</p> <p style="text-align: center;">Page 174</p>	<p>1 I think, when children and young people get lost in the</p> <p>2 system.</p> <p>3 I think, as William has said, we need to do both,</p> <p>4 which is strengthen local accountability while also</p> <p>5 making sure that system accountability -- very</p> <p>6 important, particularly in relation to transparency and</p> <p>7 enabling local people to be able to compare how well</p> <p>8 their neighbourhood is doing with somewhere else, that</p> <p>9 they can be part of that challenge.</p> <p>10 But I think from a system accountability</p> <p>11 perspective, we need not to get in the way either. We</p> <p>12 need to be really sure that what we are doing adds value</p> <p>13 to the answers to these questions.</p> <p>14 MS KARMY-JONES: Thank you.</p> <p>15 Clarisser?</p> <p>16 MS CUPID: For me, it is about developing a culture where</p> <p>17 people feel confident enough, they feel safe enough, to</p> <p>18 actually raise concerns. It is about training and</p> <p>19 development, and echoing what everyone else has added on</p> <p>20 today, but for me it is definitely about having that</p> <p>21 culture that makes people feel safe that they can report</p> <p>22 concerns, and holding the child at the core of</p> <p>23 everything.</p> <p>24 MS KARMY-JONES: Helen? You have addressed it to some</p> <p>25 extent.</p> <p style="text-align: center;">Page 176</p>

<p>1 MS CHRISTODOULIDES: The word I would add, and I think 2 people have said it in a different way, is empowering 3 people, empowering our young people, empowering our 4 staff. 5 We have mentioned accountability. And I think 6 strong leadership in organisations. We have talked 7 about that, about organisations setting the tone by 8 executives, chief executives, setting the tone, being 9 authentic about their leadership and allowing that to 10 resonate out through the organisation. That is crucial. 11 MS KARMY-JONES: Thank you. 12 Rhiannon? 13 MS BEAUMONT-WOOD: I would agree with all of the comments 14 that have gone beforehand, and I want to also emphasise 15 the importance of leadership and culture at all levels. 16 But I think I also want to say that that can't be 17 all about the top down and that, actually, that ethos of 18 continual improvement actually needs to be from the 19 bottom up. 20 I think one thing that we could do to strengthen all 21 of our organisations is to wholeheartedly be able to 22 demonstrate how we comply, if you like, with the 23 United Nations' Rights of the Child. I think that was 24 very, very evident in organisations, and I think one 25 thing that we could do -- and we certainly do it in some</p> <p style="text-align: center;">Page 177</p>	<p>1 into accountability as well, is a critical issue from 2 you having set the right tone of expectation. 3 MS KARMY-JONES: Thank you. 4 Kate? 5 DR CHAMBERLAIN: Just to give the other side of that, 6 really, and to echo the comments that were made by 7 particularly Eustace about the educated and informed 8 public, which I think is really important, but the other 9 part that has to be there is, if the educated and 10 informed public are uncomfortable or not happy with 11 what's happening, is it clear where they can go, where 12 they can get the support; is the advocacy there; are the 13 lines available to them to be able to raise those 14 concerns and feel that they are going to be heard and 15 listened to? I think the presence of the public in 16 every interaction means they are one of the most 17 powerful agents of change. 18 MS KARMY-JONES: Thank you. 19 MR LUCAROTTI: I support the emphasis on professional 20 curiosity that's been mentioned by a few people today. 21 I suppose that would then lead to some degree of 22 analysis of where we go with soft intelligence and its 23 status. 24 Speaking from a regulatory point of view, soft 25 intelligence is often the start, but, clearly, what's</p> <p style="text-align: center;">Page 179</p>
<p>1 of our performance and planning approaches -- is 2 actually have a peer-review-type process that allows 3 critical friends, if you like, rather than the 4 sledgehammer to crack a nut. I think it has to be about 5 the emphasis on learning. Because, actually, that 6 challenge of, one minute you have to be in a command and 7 control situation because it is an emergency situation, 8 and then the next minute we want people to flip in to be 9 able to escalate a concern, it is actually a very 10 nuanced thing to do. So I think the peer review might 11 help with that critical challenge just becoming more 12 embedded within healthcare settings. 13 MS KARMY-JONES: Simon, is there anything you want to add to 14 that? 15 MR DEAN: I am in danger of repeating what others have said, 16 but I strongly believe that leadership sets a culture 17 which, in turn, drives practice, and, to me, the 18 leadership is the key issue here. Again, I don't mean 19 just from the board or the chief executive, it is 20 individual leadership, it is team leadership, 21 organisational leadership and the system leadership. 22 That needs to be supported by and underpinned by 23 frameworks, policies, legislation and appropriate 24 regulatory mechanism. 25 So I think the leadership piece, which takes you</p> <p style="text-align: center;">Page 178</p>	<p>1 been carried out with that soft intelligence from an 2 employer point of view is key often to the direction the 3 case takes from a regulatory point of view. 4 So, yes, as much soft intelligence generating and 5 processing and understanding as is possible, but an 6 awareness that that, certainly from a regulatory point 7 of view, is often the start of the journey. 8 MS KARMY-JONES: Thank you. 9 William? 10 MR VINEALL: I think making clear that local organisations 11 are the first line of accountability is vital, and that 12 boards need to report and understand data and challenge 13 it and encourage those in the organisation to do the 14 same. 15 MS KARMY-JONES: Thank you. 16 Vimal? 17 DR TIWARI: Coming back to something I said this morning 18 about the importance of child health education in 19 prevention of child sexual abuse, general practitioners 20 are generalists, but our training period, our 21 postgraduate training period, is two years less than 22 that of hospital specialists, and what's missing is the 23 child health element. What is missing from our 24 contractual obligations is a child health element. 25 There is an urgent need for that to be pulled into our</p> <p style="text-align: center;">Page 180</p>

<p>1 education, our practice, our policies, and everything we 2 do. 3 Without understanding how abuse affects the whole 4 child, we can't set out to prevent it. 5 MS KARMY-JONES: Thank you. 6 Lorna? 7 DR PRICE: I know we have been talking about fragmentation 8 of the system in England. I think in Wales, over the 9 years that I have been practising, we have developed 10 a more joined-up and mature safeguarding system. 11 I spoke earlier about the NHS Wales safeguarding 12 network. 13 But to go back to sort of education and learning, 14 I think what we have also done is to try to develop 15 a more multi-agency/multi-disciplinary system of 16 education, so within peer review for doctors, for 17 instance, different specialities other than just 18 paediatrics, child health. 19 In our team, for instance, we have a GP who is 20 a named GP for Wales, and our child practice reviews, 21 which have replaced serious case reviews in Wales, are 22 much more about bottom-up learning, learning from 23 practitioners, having multi-agency/multi-disciplinary 24 learning events, and also, when concerns don't reach 25 that level, having multi-agency professional forums to</p> <p style="text-align: center;">Page 181</p>	<p>1 violence abuse organisations and working in partnership 2 to achieve best practice? 3 It is not my question; that is from one of my 4 colleagues. Thank you. 5 MS KARMY-JONES: We touched briefly on the engagement with 6 victims and survivors, I think, Susan. Did you want to 7 add anything in response to that query? 8 MS WARBURTON: Just to reinforce the fact that all elements 9 of the five-year forward view and its creation involved 10 a range of individuals, including survivors and service 11 users. So those documents in themselves had a lot of 12 engagement from children and young people in those 13 elements of those documents. 14 There has also been specific involvement with 15 survivors of sexual abuse in the development of some of 16 those specific services. So I mentioned the Sexual 17 Abuse and Assault Service, and that was very much 18 influenced by the comments early on which took it from 19 looking at one particular service to actually a pathway 20 of care, and a trauma informed pathway of care, and that 21 was directly because of the work that survivors did with 22 us to help us understand at NHS England that we needed 23 a broader pathway than perhaps we were planning. 24 MS KARMY-JONES: Thank you. 25 I am going to turn to Mr O'Mara. What changes would</p> <p style="text-align: center;">Page 183</p>
<p>1 share learning. 2 I think what I will take away from today that we 3 could use to improve our systems would be the ideas 4 about having an educated and informed public, and also 5 very much about including survivors and consulting with 6 them in trying to develop services and improved systems 7 going forward. 8 MS KARMY-JONES: Thank you. I am just going to turn now to 9 the public gallery and see whether anyone in the public 10 gallery wants to make a contribution around that 11 question? 12 Observations from the public gallery 13 MS TUCK: Again from my colleagues that have been watching 14 the live stream, the five-year forward view, to what 15 extent have you included survivors in the five-year 16 forward view, their comments, their lived experiences? 17 Have you spoken to children in this five-year forward 18 view? 19 Often policies and procedures are put in place 20 without consultation with the end users' involvement so 21 it is not fit for purpose, so if anything is going to be 22 put in place going forwards, to maximise it, to make 23 sure it does work, then it does need the end user 24 involvement. 25 Are health actively engaging with specialist sexual</p> <p style="text-align: center;">Page 182</p>	<p>1 you say have the biggest impact? 2 MR O'MARA: Nigel O'Mara, East Midlands Survivors. 3 I think one of the biggest changes which seems to 4 have been highlighted today by the gentleman talking 5 about the Welsh model being different from the English 6 model, it seems that, although it is not there by name, 7 there seems to be a form of mandatory reporting within 8 that, so that when people do have concerns, they do need 9 to log it and they do need to make it clear in going 10 forward that there is a concern so that if there are 11 several small concerns raised, that can automatically 12 trigger a larger investigation. 13 MS KARMY-JONES: Thank you. Just by way of reminder, 14 because we are getting to -- we are past, indeed -- the 15 close of the session, but tomorrow we are covering 16 culture and leadership, and we will pick up with some of 17 the things that have been raised today that we have gone 18 into a little bit but we would like to go into a little 19 bit more detail, things like: how do you go about 20 raising concerns; the questions around whistleblowing 21 and whether that is an appropriate word to use or not; 22 the issues around staff, parents and children; advocacy 23 for children -- one of the questions that was raised in 24 the public gallery; creating the right environment for 25 disclosures to be made and reporting.</p> <p style="text-align: center;">Page 184</p>

<p>1 We will also look at how we support people in                  2 thinking the unthinkable and the training perhaps that                  3 needs to be gone into.                  4 I know not everyone here is going to be back with us                  5 tomorrow, so can I thank everyone who has attended                  6 today, and just ask those who will return to give some                  7 reflection overnight to those points.                  8 Unless there is anything, chair and panel, that you                  9 wish to raise at this stage for consideration tomorrow,                  10 this might be an appropriate moment?                  11 Closing remarks by THE CHAIR                  12 THE CHAIR: No, I think you have covered some of the issues                  13 that I was hoping you were going to address tomorrow in                  14 what you have just said, Ms Karmy-Jones. So my thanks                  15 to everyone for their participation today and thanks to                  16 yourself and the team for all of the arrangements that                  17 were made and for it going so smoothly.                  18 Thanks also, particular thanks, to the two people                  19 whose words we heard this morning on the video.                  20 We will reconvene tomorrow at 10.00 am. Thank you                  21 very much.                  22 (4.05 pm)                  23 (The hearing was adjourned to                  24 Wednesday, 27 September 2017 at 10.00 am)                  25</p> <p style="text-align: center;">Page 185</p>	<p>1 Session 2: Opening remarks by MS .....108                  2 KARMY-JONES (continued)                  3                  4 Discussion re Topic 2 .....109                  5                  6 Observations from the public gallery .....147                  7                  8 Discussion re Topic 2 (continued) .....150                  9                  10 Observations from the public gallery .....182                  11                  12 Closing remarks by THE CHAIR .....185                  13                  14                  15                  16                  17                  18                  19                  20                  21                  22                  23                  24                  25</p> <p style="text-align: center;">Page 187</p>
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