Wednesday, 27 September 2017

(10.00 am)

Welcome remarks by THE CHAIR

THE CHAIR: Good morning, and welcome to everyone. This is, as you know, the second day of our seminar on understanding current approaches to the prevention of child sexual abuse in healthcare settings.

For the benefit of anyone who was not here yesterday, I am Alexis Jay, and, again, as you will know, I am the chair of the Independent Inquiry into Child Sexual Abuse. Also present are the other panel members: Ivor Frank, Professor Sir Malcolm Evans and Drusilla Sharpling.

I am pleased to welcome again those of you who have agreed to take part to assist us, and to see those of you who have returned to the public gallery, and also some new faces, so thank you very much. Welcome to everyone.

I am not going to repeat my opening remarks of yesterday. A transcript is available on the inquiry website, as is a video of yesterday's proceedings.

Yesterday's discussions were helpful and constructive. The panel and I are looking forward to continuing it today, as our focus moves to matters of culture and leadership within the relevant

organisations, and we also want to pursue what has been learned from other reviews.

Today's session will again begin with a short video in which we will hear the experiences and views of people who have experienced child sexual abuse within a healthcare setting or by a healthcare professional. The panel and I would again like to thank those who have contributed to the making of the videos.

The seminar will be facilitated, as yesterday, by Ms Riel Karmy-Jones QC and will be live streamed over the internet with a short delay so those who are unable to attend in person may follow the proceedings.

Once again, thanks to everyone for participating and to those of you who have taken the trouble to be present today in the public gallery. I will now hand you over to Ms Karmy-Jones.

Session 3: Opening remarks by MS KARMY-JONES

MS KARMY-JONES: Thank you, chair. Just some brief opening remarks, as we are starting a new day.

My name is Riel Karmy-Jones. I am a barrister, and one of my areas of expertise, as most here know, is in criminal cases involving sexual abuse, particularly sexual abuse of vulnerable victims.

I am also instructed as one of the lead counsel to the inquiry.

Can I introduce, sitting with me, Rebecca Chaloner, director of the health portfolio; Jennifer Byrom, health policy lead; Patrick Harrison and Bethany Atkinson, who are both health policy and engagement officers, all of whom have been instrumental in putting together the programme for this seminar today.

It is a new day. It is actually half a day. We are only sitting until lunchtime. I am going to ask the participants, for the purpose of the video, to introduce themselves, please.

Remember to turn the mic on, as you have been told, and can I start with Vimal, please.

Introductions

DR TIWARI: Good morning. I am Vimal Tiwari. I am a practising GP, a named safeguarding GP in West Hertfordshire and I am here representing the Royal College of General Practitioners.

MR VINEALL: My name is William Vineall. I am the director of acute care and quality at the Department of Health. I am going to be here until just after 11 o'clock and my colleague, Mark Davies, who is sitting over there at the moment, who is the director of population health at the department, is going to replace me after that.

MS KARMY-JONES: Thank you very much.

DR DEBELLE: Hello, I'm Geoff Debelle, a consultant

paediatrician at Birmingham Children's Hospital, and I am the officer for child protection for the Royal College of Paediatrics and Child Health.

MS SUTTON: Good morning. I am Moya Sutton. I'm the senior safeguarding lead for NHS England.

MR DE SOUSA: Good morning. I am Eustace de Sousa. I am the national lead for children and young people and families in Public Health England.

MR DEAN: Hello, my name is Simon Dean. I am the deputy chief executive of NHS Wales.

MS CHRISTODOULIDES: Hello, my name is Helen Christodoulides. I'm a director of nursing at Leeds Teaching Hospitals Trust.

MS BEAUMONT-WOOD: Good morning. I'm Rhiannon Beaumont-Wood, executive director of quality nursing and allied health professionals in Public Health Wales, but here today representing nurse directors NHS Wales.

MS CUPID: Good morning. I am Clarisser Cupid, I'm a designated nurse for safeguarding children and I'm here for NHS Southwark Clinical Commissioning Group.

MR HEANEY: Good morning. I'm Albert Heaney. I work at the Welsh Government as director for social services and integration.

MS GALLAGHER: Hello. I'm Professor Ursula Gallagher, I'm deputy chief inspector at the Care Quality Commission

and within my portfolio I'm the lead director for safeguarding and also for the inspection of services for children and young people and prison health and justice.

MR McMORROW: Good morning, I'm Ray McMorrow, I'm the Royal College of Nursing representative and I work for the National Working Group for tackling child sexual exploitation within the response team. I'm a mental health and safeguarding nurse by background.

DR CHAMBERLAIN: Good morning. I'm Kate Chamberlain. I'm chief executive of the Healthcare Inspectorate in Wales.

MS HORSLEY: Good morning. I'm Angela Horsley. I'm head of children, young people and transition, NHS Improvement.

MS KARMY-JONES: Thank you very much. Now, no discourtesy is intended, but as with yesterday, I am going to ask all of you questions by using your first names. Again, I don't mean to be impolite. It is just far simpler. By all means, use my first name too.

As with yesterday, we have a lot of ground to cover today, but please remember this is not a formal evidence-gathering exercise. It is not the forum for cross-examination or interrogation, and we are not here to launch criticisms against individuals or specific organisations. To follow through with that, I am going to ensure that only comments, observations, contributions and questions only around clarification

are taken during the seminar.

When speaking of experiences, be careful not to mention the names of individuals not present, please.

A couple of reminders to the public gallery. We will follow the same format as yesterday. At the end of each session, we will take a little time, depending on what's available, to give you an opportunity to comment and to raise issues which we can consider over the short break and may be able to weave into the discussions thereafter.

Please remember, all, that because of the function of the panel, they are unable to engage in the way that others can. They have a role within the wider inquiry that is a judicial role, so it is necessary that they remain impartial and without bias. So they are not able to answer questions or express views here today.

It goes without saying that today some of the material we have may be sensitive, and in fact, particularly today, there are some matters that are going to be addressed that are of a sensitive nature. Terri and Hannah are here. They have been introduced to you. Please use them, if necessary. If you feel upset, there are rooms available for quiet and confidential discussion.

Now, yesterday, we heard on the video, as the chair

has said, from survivors. Yesterday, it was a male and a female survivor. Today, there will be two female survivors of child sexual abuse within a healthcare setting, Alison and Claire. Those are not their real names, and they are, for the purposes of this, in silhouette and played and voiced by actors. So I am going to ask for that video to be played now, please.

(Video played)

MS KARMY-JONES: Our thanks, again, to those who agreed to share their views and experiences with us through the medium of the video.

Session 3: Opening remarks by MS KARMY-JONES (continued)

MS KARMY-JONES: The subject of this final session of the seminar, this half day that we have in front of us, is the role that culture and leadership play in the effective prevention of child sexual abuse within the healthcare system, something that came up a great deal yesterday. Broadly speaking, we are dividing today into three topics: staff; parents and children; and overarching culture and leadership, which will touch upon the recommendations and how and whether they have been properly implemented.

Yesterday, we had a very useful discussion, as the chair has said. There was a great deal said about the complexity of the situation: the fact that there needs

to be education and training; that there needs to be consistency of approach; that the diverse bodies, some of whom are represented here today, need to come together to consolidate views, regulation, guidance; that soft intelligence should be disclosed; that potentially there need to be stricter sanctions on perpetrators in terms of erasure, amongst many other things. There were also discussions around data and that it would seem that no-one really knows size or extent of the problem, and there may be issues with collating data and disclosing it.

One thing that was notably lacking was any detail about what it is we are really actually speaking about, which means that we run the risk, certainly, of looking at this in the abstract, of getting lost in platitudes about policy, about professional curiosity, and not addressing what is really true awfulness that occurs.

So let me just describe some of what really takes place, which I am confident that many around the table are familiar with, that sometimes it is easy to push to the background.

We looked at the Verita report investigation for Cambridge University Hospitals, and looked at press reports at the time of the conviction and appeal of Dr Myles Bradbury. He was a paediatric haematologist

working as a blood cancer specialist at Addenbrooke's Hospital in Cambridge for five years. In September 2014, he pleaded guilty to 25 sexual offences against children, children who had been his patients, whom he had abused between 2009 and 2013. He offended under the guise of medical treatment, carrying out unnecessary intimate genital examinations of children. He used a pen, a spy pen, to secretly photograph his partially-clothed and exposed victims. He was found to possess more than 16,000 indecent images.

He often carried out examinations on children behind a curtain in the examination room with a family member in the room, but on the other side of the curtain, in breach of the hospital's chaperone policy, but no-one ever complained.

Staff noticed that he was seeing patients out of hours, but no doubt, because of his status within the hospital, they presumed that he was doing it to be kind, to help the patients out.

He saw some children more often than necessary, but failed to record those consultations. Doctors subsequently explained that Bradbury spent a lot of time ingratiating himself into families' affections and that his office wall was covered in letters and cards from

children.

He phoned families on his personal mobile number to make appointments. One nurse was quoted as saying that she thought Bradbury was bending over backwards to be flexible when he saw patients out of hours. He even went on holiday with one of his former patients and the boy's mother. When a consultant confronted him about this, he agreed he could no longer be his doctor, but that appears to be as far as it went.

He used excessive puberty checks as an excuse to assault patients, while their parents sat, unaware, on the other side of the curtain. He told families that it was "essential" for him "to see their child alone", and that they should learn to trust doctors. That's something that the independent investigation found.

One doctor did confront Bradbury when she noticed that he was seeing a boy on his own. He said it was at the patient's request. One mother watched Bradbury slip his hand under her daughter's top without warning, but she didn't want to question his professionalism. One child, who was in remission from leukemia, was asked to strip naked and touch his own genitals. It was in fact his grandmother who rang the paediatric unit and complained to reception, which led to Bradbury being suspended, but by that stage, he had been there for

a number of years and had abused at least 18 children.

After his arrest, a registrar noted from records that he seemed to be openly focused on puberty. A medical director of the Trust told the investigation that his staff were duped by Bradbury, and said of his paediatric oncology colleagues, "I think they were all groomed along the way".

Bradbury was jailed for 22 years, reduced to 18 years on appeal. Following the appeal, one mother was quoted in the press, describing the impact on her 10-year-old son who was assaulted after he was diagnosed with leukemia when he was only 7 years old. Bradbury oversaw his regular bouts of chemotherapy. The mother said:

"There are days when he's fine, but he still gets down about it. The other day, we were at a family party, having a great time, and he said, 'I wonder if Myles is having a good time'. I told him, 'Of course he isn't'. It's still hard."

The doctor was so trusted and admired by the family, they saw him as a God who would cure their son. They even sent him Christmas cards for two years with the boy's picture, and they were devastated when their young son revealed what Bradbury had done to him.

So that is the nature of abuse we are looking at.

Perhaps the comment of other staff potentially being groomed is one that feeds very much into this discussion, because the wool is pulled over everyone's eyes, isn't it, and part of this discussion is about how we stop it, how we prevent it and how we make people more alert to it.

As I outlined yesterday, we have received a number of responses from the individuals who sit around the table. Most people have sent us a response. I just want to highlight a few key points.

The importance of effective safeguarding cultures within the organisations and the role of strong and responsive leadership was emphasised in many of the submissions. A particularly strong theme was the need to create environments in which everyone -- staff, volunteers, visitors, parents and children themselves -- feel confident to speak up when they have concerns. The role of leaders, organisational leaders, in ensuring that concerns and other problems and risks are dealt with decisively, appropriately and always with the interests of the child seen as paramount was also a strong feature.

Also, stressing the importance of this, many respondents gave views about why this doesn't happen as it should, and we want to explore that in more depth.

Why doesn't it happen? We all know what needs to happen. Why doesn't it happen?

We want to use this morning's discussion to explore those matters in more detail.

How do we prevent people who mask the abuse of the vulnerable under the authority of a clinical setting that actually justifies it, because, of course, if we were in a school, and you are a parent with a child, and a teacher comes up to you and says, "Actually, could you just tell your child to take his clothes off and lie on a bench over there", of course we would raise questions. It wouldn't happen. That is not to say that abuse in schools doesn't happen. But there is something unique about a clinical setting, isn't there, that allows those kind of things to happen, because examinations are part of what takes place in the clinical setting.

How do we prevent it? What do you suggest can be done to improve the current arrangements? What effect will your suggestions have on the prevention of child sexual abuse in a healthcare setting? Why are things not happening now? Really, what are we waiting for?

So can I start by asking the question: what prevents staff from identifying and raising concerns about child sexual abuse that may be occurring within a healthcare setting? Can I ask Helen to help us with that?

Discussion re staff

MS CHRISTODOULIDES: Thanks, Riel.

I think you've mentioned some of them, and yesterday I spoke about the authority gradient, the differences between people's roles, pay bands, status, professions, that hierarchy does still exist. People, perhaps, don't know how to raise concerns, aren't sure about what they're seeing. Staff in the health service are busy and tired, and in nursing we talk about compassion fatigue, that has been written about recently, and I consider that is having an impact on staff's own morale and resilience.

I'm sure all of these things contribute to why staff don't raise concerns.

So in nursing -- I was reflecting last night. We have a strategic framework, something called "the six Cs". One of the Cs is courage. So do you have to be brave to raise concerns? I expect you do.

I am sure all those things contribute. If people have had negative experiences of raising concerns before -- in our organisation, it's quite -- you tell your line manager. Of course, there is a Freedom To Speak Up policy, we speak of whistleblowing, there are all sorts of different ways to raise a concern. But the simplest thing I always tell staff is, "Tell your line

manager". We have quite a flat structure in our organisation. You only have to tell two more people and it would come to me and our chief nurse. So it is not a long chain of people you have to get through.

I think they're the things that contribute to why staff don't raise concerns.

MS KARMY-JONES: Thank you. So fear is one of the matters that you have mentioned, in effect. Fear of reprisals, sometimes the position that someone might be in and they may fear that something will happen to them.

How well are staff, including volunteers, supported in speaking up if they have concerns that a child may be being sexually abused whilst receiving care or treatment? How well are they supported? Who can help us with this? Ursula, do you have any comments on this?

MS GALLAGHER: Well, certainly from our work -- I mean, it is clear across a whole range of issues, including child sexual abuse, that staff don't believe that they will be well enough supported. I think that there is a question of trust here.

Victims aren't believed, staff aren't believed. I think your discussion of Myles Bradbury -- and my first encounter was a very similar situation, three weeks into being a director of nursing of a local GP who was known as "Wicked Willy" on the local school

playground. It took a new practice nurse to go in and be prepared to come forward.

I think it's their lived experience, in many organisations, of speaking up. In some ways, it's -- clearly not necessarily a policy position of the CQC, but we are continuing to have these endless conversations at the extreme end called whistleblowing, and even in the papers this morning there is a discussion about a special programme for Trusts who have agreed to employ whistleblowers who have lost their jobs. If I'm reading that as a band 5 staff nurse, what am I thinking? There seems to be an expectation in some bits of the system about what would happen to them. That's about raising concerns about poor care, poor clinical outcomes from surgery, never mind getting to an extreme around child sexual abuse.

I think from our perspective, there is also something that particularly we look at in our inspections, which is about how the paradigms change. So, again, I was interested that you had a conversation about chaperoning and consent. Again, why is chaperoning not a norm? Why is it an exception to opt out of chaperoning? Why are these systems, processes and practices not so embedded that there isn't the opportunity for somebody to groom staff or to persuade

other people that it's not necessary?
I think we have also talked with staff where there are some really sophisticated interactions between, on the one hand, in relation to other abuse, the conversations about children being seen on their own, perhaps not in the context of other abusers, and then who that healthcare professional is. That is why, you know, the best organisations think about those things, which is to say, seeing a child out of a setting that they might be concerned about is not the same as seeing them on their own, and how do we make all of those opportunities safe again, recognising that sometimes these children and young people can be particularly vulnerable, and I think, quite rightly, as one of your victims mentioned on the video, it was her very vulnerability as a victim of abuse that made her more vulnerable to ongoing abuse.
I don't think that organisations talk about that enough. I don't think that teams talk about that enough. I think that most organisations from our work don't well evaluate what they've -- I am sure we will come back to training again, but input training isn't good enough. How are you evaluating its training and outcomes? How are you evaluating the difference it is making in what's going on in supervisory one-to-ones

between line managers and staff and the sorts of things that are being talked about in team meetings.
MS KARMY-JONES: Thank you very much. Moya, do you have something to say on this, and picking up on what Ursula said, but also the first point that she made, which was that staff don't belief they will be supported?
MS SUTTON: I think it would be wrong of me to generalise that that is the case across the board, because my own personal experience prior to working for NHS England, I was the director of nursing at Alder Hey Children's Hospital. We received an outstanding outstanding inspection on safeguarding and looked-after children, and staff at every level spoke out, and I think what made us outstanding, something that we were specifically and particularly proud of, was that we had very good training systems in place, interactive training, scenario-based training, "What would you do if ...? What wouldn't you do if ...?", rather than just sitting in front of a PowerPoint presentation with your eyes open, but fast asleep. So training was really important, and our staff said that.
Access to line managers and senior safeguarding specialists within the organisation who are very visible, very approachable, out of hours, in hours, so that staff know that they can connect with an individual

if they have a concern, and I know that in the Savile investigation, that was the thing that was raised with regard to not all Trusts have the same level of safeguarding resource. If you have one safeguarding leader and 2,000 nurses and other health staff, it is very difficult to connect with them.
The other thing that the inspection found, which I think is absolutely so important, is credible, visible and engaging leadership at board level. We used to have board walkabouts. We would split the board in half. We would have some scenarios to ask staff, and the board would go out, and they would go from A&E and ask the triage nurse, "So this scenario happens, what would you do? Who would you call?", et cetera, et cetera, and the board safeguarding the walkabout went from A&E to the mortuary and every step in between: specialist neurology, head injury, specialist haematology, blood-related illnesses, specialist retinology, retinal bleeding, to really get the board to have a feel of the complexity of the safeguarding programme. What was really phenomenal was, while we were doing the walkabout, we went to medical photography. What would a non-executive director be doing in medical photography? They are the people who take the photographs of the injuries, both sexual and physical.

As we were there, there was actually -- an assault had just been photographed by the photographer.
Our board got so much from that experience that we have had to repeat it periodically, but the staff got an awful lot from it as well. Seeing the chief executive on the ward asking about safeguarding training, who would they go to if they were worried, et cetera, et cetera. So it is from the top to the bottom, and it requires courage and compassion and care and competence, et cetera, et cetera, and for me, most of the lead for safeguarding sits with the directors of nursing in the Trusts, some is a co-leadership with the medical director, which I think works very well as well. But if you are accountable and responsible, the examples that I have just given should be part and parcel of your leadership role and actually talking to your staff and making them feel that they can talk to you is incredibly powerful.
MS KARMY-JONES: Can I just pick up on a couple of things. Would you say that apparent and visible training, and you have mentioned board walkabouts, which is something that's visible and means that bodies are present, would you say that those kinds of things not only help, in terms of safeguarding, but might also help to put off perpetrators, if that is seen going around the ward? Is

that a possibility?
MS SUTTON: Potentially. Potentially. It may well be.
I think there is -- in the Bradbury investigation and the Savile investigation, when you look at the details, staff knew something wasn't right. Some knew it absolutely wasn't right and some knew that they didn't think it was right. I think there was just something about really making a culture one of open and honest -- and encouraging braveness, encouraging courage. And it is with great credit -- I was humbled. We had five workshops, regional workshops, to actually raise the profile of the inquiry across the NHS, but also to use the Bradbury investigation as an example of, "This actually is happening". It was interesting, because I asked the audience, and there were about 600 delegates attended over the five events. I said, "Does child sexual abuse happen or has happened in your organisation?", and a number of people put their hands up, and they came wanting to learn how to stop it, but also to share good practice experiences with everybody else.
The individual who whistleblowed, for want of a better word, the assault that Bradbury perpetrated on that young boy was the receptionist, out of hours. Brave. She could have done one of two things. She

could have said, "I'll ring Dr Bradbury and get him to ring you", but she didn't. She automatically went straight into safeguarding practice and procedure. That is something that should be applauded and shared with every member of staff, that you don't have to be the executive nurse or the designated nurse or the named doctor. This was a member of staff who did the right thing and resulted in the right action.
MS KARMY-JONES: It would be interesting to know, of course, whether that result came from training or human instinct.
MS SUTTON: I think it was a bit of both. I think it was a bit of both. We actually use those regional events to really try to bring the system together, and only recently, in fact, over the past couple of months, the chaperone policy which had been tested and tested and tested at the Trust was finally signed off by the board. It did have resource implications, because if you want to put a chaperone in a setting where patients may be vulnerable, you have to have enough resource to do that. But we asked the Trust if they would be happy for us to facilitate that chaperone policy being shared across every Trust and provide organisation in England and that's actually happened.
MS KARMY-JONES: Can I bring William in here from the

Department of Health?
MR VINEALL: Thanks. I was going to say two things. First of all, obviously one of the government's roles is to set conditions for behaviours that we would like to see in certain public service settings, so, in a sense, whistleblowing, which started off life as something in the employment world, as Helen was saying, has now been somewhat adapted to be something about speaking up more generally when you have concerns, hence Freedom to Speak Up Guardians and all of that. The other thing we have done, which slightly played into Moya's point about the member of staff did a very good thing in those circumstances and actually behaved -- blew the whistle in the same way we have with staffs and other investigations led by whistleblowers, is we did introduce the duty of candour which put a requirement on the organisation to be open and accountable. Now, that is delivered through staff's behaviours and there is remit and guidance and quite a lot of training that's gone on since it was introduced three years ago, but that is very much to put the onus on the organisation to say these are a set of values that you are required to foster throughout your organisation.
So people, hopefully, in the fullness of time, don't have to be heroic to do the things Moya described and it

becomes something that is encouraged from the organisation, because there is a nervousness about people stepping out of line still and that needs to change.
MS KARMY-JONES: Can I go to Kate then, please?
DR CHAMBERLAIN: Kate Chamberlain, Healthcare Inspectorate. I think I just wanted to add one point to what's been said here about why maybe staff don't speak up as much, because we find quite a lot in some of the conversations we have with staff, one of the reasons they don't raise concerns -- I'm not talking about the most serious of cases, but generally -- is because there can be a lack of feedback as to what's happened to that. So there is something about, if you want it to become a normal culture to be raising concerns, you need to be providing that feedback as to what's being done with it, the fact that, you know, people are doing this across the whole organisation, it is a normal thing to do.
I can appreciate, in some of the cases we are talking about, we are talking about concerns being raised about an individual and, very often, an organisation will say, "We cannot share issues relating to personnel matters", but you can, I think, be far more visible about sharing maybe -- in the spirit of continuous improvement -- the number of issues that have

been raised by staff, the type of actions that are being taken by the organisation to respond to them, and I think that can be part of what's lacking in some organisational systems in terms of building that culture of encouraging people to speak up, and it comes back to what you were saying about bravery. Some situations will require bravery, but actually, there will be lots of situations where you just want it to be part of the normal flow of daily business.

MS KARMY-JONES: So there is a fine line there, isn't there, between a culture of being able to speak up and balancing that with a culture of confidentiality?

DR CHAMBERLAIN: Yes. But what struck me in listening to the introduction you gave on that particular case is that, actually, it wouldn't have been difficult to raise challenge to unusual behaviours or behaviours which were outside of normal policies and whether that was appropriate without it being seen to be necessarily a direct attack on an individual.

MS KARMY-JONES: Thank you. Rhiannon, can I bring you in here?

MS BEAUMONT-WOOD: I agree with a lot of the discussions, and certainly in Wales we have, I think, very robust safeguarding focus and teams. But I actually think there is a significant leadership role in this space for

our workforce directors, because, actually, when things are of a level of concern where perhaps the evidence to support that is not yet robust, some of the discussions that then ensue, it is very much, you know, the strong leadership of perhaps the director of nursing or the head of safeguarding with the workforce director to kind of remind everybody that safeguarding legislation trumps all, but obviously when we get into, you know, perhaps unions involved in discussions, it's about everybody understanding their roles and responsibilities and which policy and procedure and guidance applies in what context.

Some of that can be quite nuanced when the level of concern -- yes, it is there, but the evidence to back it up isn't yet there.

I think, just to add, in Wales, at the point where a concern would be raised, we would be expected to put that duty to report into local authority. So already there is a third pair of eyes, if you like. We are not marking our own homework. That happens very quickly, and what we describe as a strategy meeting will happen quite quickly. But I think it is just -- I can't say -- I think it is important that we just ensure that our workforce directors get investment in training and understanding. They do, but I think there is more we

could be doing at the senior leadership end around that.

MS KARMY-JONES: I think we have got the point that it is important to have leadership, but how does that translate in practice? Rhiannon, you have given us a couple of examples. But how do we get employers to take on board their responsibility to create a culture where speaking up is encouraged and supported? What do you expect people to be doing and saying that they aren't currently doing and saying? How do we take this forward? Rhiannon, you have your finger on the button.

MS BEAUMONT-WOOD: Sorry, I thought you were directing it at me. Well, it is a board responsibility, and it's Simon's point yesterday: as a board of individual NHS organisations, the board is accountable for ensuring arrangements are in place. But I think it is when we get into the practicalities of applying things.

So, for example, members of staff who want to raise a concern also want to feel confident that there will be a level of anonymity, and the reality is, that actually can't happen. It can't happen on a number of levels to kind of pursue with the safeguarding investigation, even if it doesn't go down that route, it might be other kinds of concerns that have been alluded to. There can be subject access requests for all records. For example, the person who is trying to defend concerns

being raised against them may raise a claim or may raise a grievance.

So I think it is just about understanding this context is quite challenging for a number of reasons, and although, absolutely, the culture at the top and the middle and the bottom is about driving that understanding of raising concerns, there's quite a lot of complexity in various pieces of legislation that has to come together and the policies that fall out of that.

MS KARMY-JONES: So would someone like to think about what Rhiannon said? We have heard some good examples. We have heard, you know, board responsibility. But what do we actually need to see happen on the wards. Vimal?

DR TIWARI: Vimal Tiwari, RCGP. Something that hasn't been mentioned really is the medical profession's role in this. One of the things I do in my role as a named GP is teach other GPs. I have been doing this for the last 40 years.

So from time to time, young doctors just coming into general practice have mentioned that they have been working in institutions where everything is swept under the carpet, and I don't think it is possible to underestimate the power of certain institutions in this country to be able to suppress information and the importance to junior doctors of making good impressions,

having good references to be able to succeed in their careers, they are very intimidated in certain environments and feel quite unable to speak out.

I think one measure, one possible measure, of what's happening in a particular locality could be looking at the serious case reviews, just to give a snapshot of what's happening. Because in some parts of the country, there are very, very few serious case reviews. I'm not saying that's an absolute measure of openness and candour, but it could be an indication of the willingness of agencies in that area to examine practice.

MS KARMY-JONES: Thank you. William?

MR VINEALL: My comment was actually slightly related to that and also what Rhiannon was saying. One of the things we know the NHS is a bit variable about is its ability to do investigations well of any kind, because it is not recognised as a skill set in its own right.

So there's been quite a lot of work going on in the government in recent years, including setting up a new organisation, that is trying to give training and support to encourage people to do investigations better. If people have the ability to do investigations better, then, as Vimal says, numbers of things like serious case

reviews and the like may go up, and that is a sign that an organisation is actually addressing issues rather than perhaps ignoring them. It comes back to the point we made yesterday about numbers: higher numbers in all of these areas may be an example of you being a rigorous organisation, not a bad organisation, although that is obviously a difficult thing to communicate in the first instance.

MS KARMY-JONES: And no doubt difficult because they may feel that highlighting those instances makes it look at least like they are unique or they have more instances to worry about.

MR VINEALL: Yes.

MS KARMY-JONES: So there is a kind of punitive effect by doing their job properly as well.

MR VINEALL: Yes, and that needs to be turned into a virtuous circle rather than the opposite.

MS KARMY-JONES: Exactly. So we have got the idea that there are reviews and investigations, but what I would like to ask, particularly, perhaps, of Clarisser and Helen, is, can you give some good examples from the frontline -- good examples of bad leadership and perhaps some good examples of good leadership that sort of inspire staff members to act properly, to report, not to be afraid of reporting? Can you think of any that you

can share with us? Helen?

MS CHRISTODOULIDES: I can probably give lots, but not in the context of child sexual abuse or safeguarding particularly, and Clarisser, in her role, might be able to think of them.

MS KARMY-JONES: Can you think of any, Clarisser?

MS CUPID: Clarisser Cupid, designated nurse.

I can think of examples of -- in terms of leadership. Probably not exactly relating to child sexual abuse. One of the things that we have to remember, and I remember mentioning that yesterday, is that we cannot work in isolation.

Staff members may feel, "Oh, one of the roles is that we empower staff to feel confident enough to raise a concern". One of the things that might be a barrier to staff raising that concern is that they may feel they don't have the evidence, they just have that feeling.

Sharing that concern may actually open up more information, because one thing we do know is that we don't hold all the information, and just sharing that concern, you might actually identify that, actually, this issue has happened with other cases, or other staff may feel the same way.

Working on a multi-agency setting actually opens that even further for you, because within health, we

don't know what else that member of staff we have got a concern about is doing outside of our organisation, and working with our partners might be able to help us to identify the extent of the concern.

So in terms of leadership, I'm very much focused around safeguarding team actually being visual, being there for staff members to feel confident enough that they can raise a concern, and actually taking that concern seriously enough to do something about it and feeding that back. So for me, that is an example of good leadership.

MS KARMY-JONES: That feeds into one of the terms that was used yesterday. So you have a concern and at what point does the concern become something that is raised. One of the things that was said yesterday was that we need to encourage "professional curiosity". That was used on a number of occasions by different people.

What exactly does that mean? How do we develop that? How do we develop that sort of culture of encouraging professional curiosity and who sets the boundaries of what is and what is not acceptable?

MS CUPID: Clarisser Cupid, designated nurse.

It is through training, education and development, but also through supervision. I think that is probably something we haven't explored to the extent that we

should. Supervision is key, because that gives that practitioner and their supervisor the opportunity to scrutinise, to raise concerns, to challenge decisions, to challenge any information, but also to ask the question. So in terms of professional curiosity, it is going beyond the norm and asking deeper questions.

Sometimes, I think frontline practitioners are so busy that you avoid those questions because you don't want the answers because the answers mean you will have to do something about it. But by developing a culture where people feel confident enough to ask those questions and are given the time to deal with that situation or to deal with the answers that they get, that's really important. But supervision is key, along with obviously training and development.

MS KARMY-JONES: Thank you. Is there anyone who would like to add to that?

MR VINEALL: It is only a small thing. We touched on it yesterday. Obviously, one of the big changes in professional regulation is we now have revalidation, which has been alive in the medical profession for three or four years. It came in for nursing last year. Obviously, that is a way of resetting and checking about how people are like in terms of the breadth of their professional behaviours rather than saying, "Once you

have qualified at a young age, you are therefore all right for the remainder of your career", so it gives check points.

MS KARMY-JONES: I think Ray first, and then I will come back to Simon.

MR McMORROW: Ray McMorrow, Royal College of Nursing.

Going back to something Helen said quite a bit earlier about the busyness and how people are, you know, I noticed this morning one in ten nurses are off sick with stress or depression. If one looks at serious case reviews in detail over the years, one of the things that really is missing is the focus on the relationship.

In health in particular, we can be very focused on technical interventions, and actually, what we have found is -- I think Clarisser sort of touched on this -- actually, if something else is happening in somebody's life and the organisation isn't tuning into that, that's often when things go wrong in the workplace, when they don't do -- you know, 90 per cent of the time or 99 per cent of the time people may make the right decision, but in the moment of crisis, where there are additional crises in their life, they often don't make the right decision, and we see that through serious case reviews, but it very rarely comes out in the recommendations around those serious case reviews.

Increasingly, we are aware that, actually, supervision in those areas and the work of the Munro studies which has largely focused on social care, but it is that issue about, do we, within health, consider what the practitioners -- whether they're doctors, nurses, allied health professionals, the receptionist, what they bring to the table themselves? Do we attend to them as people? Because if we don't attend to them as people, then whatever systems of leadership we put in, actually, people will make decisions that breach those decisions or will not be courageous at the time.

So in fact we need to promote -- there was another word used yesterday, which was "constructive mistrust", which I really liked, it came from the Professional Standards. I think that's something we have to promote that's shared across what are very hierarchical structures, that everybody can carry out their work with constructive mistrust but also the opportunity to bring their own challenges to the table to focus, and that goes all the way back to pre-qualified training as well.

MS KARMY-JONES: Thank you very much. Can I turn to Geoff. I have a number of names, but in order, Geoff, you had something you wanted to raise, I think?

DR DEBELLE: No, I didn't. I tend to agree with everything. It is just this notion of professional curiosity which

you questioned. I'm thinking of some situations, survivors, victims, often say, "If only somebody had asked me ..." I'm just wondering, in terms of our training, there must be a lot of body of evidence that's accumulated now on how you pick up specifically non-verbal cues that a victim may be giving to staff. Maybe it is on the night ward, often where disclosures are given in a very non-verbal situation. It is very, very difficult -- extraordinarily difficult in a busy paediatric outpatient department to pick up some of these cues. But I think we need to, and I think that's part of our college remit, to train our colleagues, paediatricians, on how to pick up non-verbal cues, how to listen.

It is another matter entirely now. I agree with everything that Moya has said in terms of walkabouts and having the right safeguarding culture, but I think, in a number of NHS institutions, a lot of members of the college are coming to me and saying, "I don't have sufficient protected time to do my work as a safeguarding doctor or nurse, I'm not given protected time. The Trust don't value this work". A lot of Trusts do, but a lot of Trusts, it's added on and it is not embedded within the culture. So a lot of my colleagues are fighting to get sufficient time to even

do their safeguarding work. But I think it is a huge training issue around this notion of professional curiosity, because it comes up in every serious case review, and it has almost become a glib phrase now, so I'm glad you have questioned it.

I don't know. It is extraordinarily difficult. If a nurse is in a busy outpatient clinic and the doctor doesn't get a chaperone and she asks why, and he says, "Well, I'm sorry, it is just going to take up too much time", now, what does that nurse do? That doctor may be perfectly correct, that it is just going to make the clinic unmanageable, or she may be onto something. It's extraordinarily difficult.

MS KARMY-JONES: A part of it, of course, another phrase that was used yesterday, and I think again this morning, is training people to think the unthinkable. So even in what looks like a reasonable situation where the doctor is very busy, he can't get a chaperone, that happens, we know that happens, but how do you deal with it? How do you take that -- if there is an instinct, how do you take it further?

DR DEBELLE: So there must be a way somehow within the institution, as people have been saying, where that nurse can talk to someone and know that that someone will go further and, if that someone doesn't go further,

then he or she needs to be able to go even further still, and yet remain completely plausible.

What happens if he or she is wrong? Who judges them to be wrong anyway?

MS KARMY-JONES: And what does that do to the relationship, of course, between the doctor and the nurse?

DR DEBELLE: Yes. I am going to come to Moya, because I think you are going to follow on on something Geoff said and then I am going to move around. I have Simon to turn to along with a couple of others, I think Albert as well.

MS SUTTON: I think my experience I described many years ago was a very positive one, but I think a fairly small specialist Trust where lots of very good relationships are built up over many, many years. I think if you think about the likes of Leeds Teaching Hospital, on different sites, huge, it is very, very challenging. And I would agree with you, I think it certainly came through in the recommendations in the Lampard Report, that some organisations don't have the right resources for safeguarding, and that includes the doctors, the midwives, et cetera, et cetera.

But one of the things I have found wholly inspiring when I worked with the team involved in the Bradbury investigation was that there is another set of eyes and

another set of ears and a mouth that can be used to challenge some of these things, and it is parents, children, young people knowing what to expect and knowing what not to expect.

So if a doctor says -- if the mother says, you know, "We need to get my child seen now because I have a bus, I have to collect another child from school", et cetera, et cetera, there has to be a conversation from the outset with parents and children and young people about what is right and what is not right. Very, very few patients and their families now would accept the laying of hands from a healthcare worker who hadn't washed them. So there is this whole cultural drive about what you should expect from a chaperoned situation or a non-chaperoned situation, what shouldn't happen and what you need to do to stop it happening. That is about giving our patients and their families a strong voice here to say, "No, stop. That's not acceptable" or "No, I'm not happy with that". There can be some really creative and innovative ways of doing that, and I think we should look to the team at Addenbrooke's who have done a lot of work in this area.

MS KARMY-JONES: We are going to come on in a moment to parents and children, but before we do that, can I turn to Simon. You had something you wanted to contribute?

MR DEAN: The wider point about leadership, you said in your introductory remarks, "We all know what needs to happen. Why doesn't it happen?" I think that is quite telling, and I suspect we do know what needs to happen.

We talked yesterday about other examples in where progress has been made, healthcare-acquired infection campaigns, "Hello, my name is ..." What has made those things successful? That might be applied in this situation. I think it is a question that you asked yesterday. I would say that it is about the priority given to those things by leadership.

The example that you gave is of a board that had organisational curiosity about this issue. So what was it that in that organisation made this topic a subject that grabbed the attention of the board? Because leaders are busy people. Leadership is a wide range of responsibilities, a wide range of priorities. So how do we make this a visible priority for leaders? Because that board, in taking those actions, will have done something to create a culture, to shape a culture, which will allow individuals, I would argue, to operate within their professional culture, but within a context, where they know their organisation is interested, sees it as important, because there are very visible signals. I think there are parallels with things like

healthcare-acquired infections and others where these become very important.

It would be quite interesting to look at the board minutes of NHS organisations and ask the question, "How many times is this topic on agendas?" I suspect we would find that the answer is, not very many. Whereas other topics will tend to dominate. So there is something about what grabs an organisation's sense of organisational priority and curiosity that I think will help drive the right culture.

MS KARMY-JONES: That's interesting, because it also ties in with that issue around data and the questions that William raised earlier about, you know, leadership putting the interests of children ahead of reputational concerns, releasing that kind of data, releasing the minutes of board meetings where these things are discussed, and I see nods, so presumably that resonates with some of those around the table.

How big an impact has something like the Freedom to Speak Up Guardians had at a local level? Can anyone tells us about that? Is there anyone who can --

MR VINEALL: They are starting to have an impact. I mean, obviously they were the upshot of what happened after the Mid Staffs and the Morecambe Bay investigations, and the numbers of cases reported in the first year have

gone up.

There is a place where I think people can come and feel they have somebody they're able to turn to if they have a concern. They have been able to put on some training about how these things are taken forward. But they have only been established for a year. So I think they're established and doing a good job, but there is more to build on.

MS CHRISTODOULIDES: I think -- if I went out into my organisation and said, "Do you know what our Freedom to Speak Up Guardians are", you can bet your bottom dollar not lots and lots of staff would. But would they know that they can talk to their line manager, talk to somebody. So it is part of a package, isn't it, of cultural change in organisations about duty of candour, honesty, openness, integrity, understanding, you know, the board walkabouts that they do. I couldn't think of an example before, Riel, when you asked me, but it popped into my head before about, I say to my head of safeguardings, "Please can you be here at 10 to 5 on a Friday?". I joke about it, "Please will you just be here?", because the phone will ring, I know it will, and it will come through to me and it will be a sister on a ward saying, "This has happened, and what shall we do?", and they ring me and they would -- that's why

I want my head of safeguarding there, just to check I'm saying the right things, but that's fine, because that is good leadership. I'm accessible, the chief nurse is accessible, that nurse knows that if she's worried about something, you pick up the phone and -- because they know me, they know us, they know the senior people in the organisation. We're setting the tone. We're saying -- I'm not a Freedom to Speak Up Guardian, but that doesn't matter. You can tell me anything, raise any concern with me.

Often things come to us and we think, "Oh, what shall we call this? Shall we call it a Freedom to Speak Up concern, or shall we call it a complaint, or has it come through the Datex system through our incident reporting?" It doesn't matter to some degree, it doesn't matter. What matters is, we acknowledge it, we respond to it, we support the person, we thank the person. I have said, "Thank you" before to nurses that have written me letters about concerns around care, not about child sexual abuse, but other aspects of care, and we work together and involve our staff in finding a solution or finding the least worst option sometimes because often there isn't a perfect answer.

So do people know about Freedom to Speak Up Guardians? Some people will. Does that matter as much

as the culture I have described? Probably not.

MS KARMY-JONES: Do you think sometimes it can actually cause an impediment because there is so much almost red tape without actually getting to the point, which is, you should just react in the way that you should react?

MS CHRISTODOULIDES: Yes. I think -- yes, we can't make it complicated for staff. Sorry, William, go on. I know you --

MR VINEALL: No, you finish.

MS CHRISTODOULIDES: No, that's it.

MR VINEALL: I was only going to acknowledge your point about is there too much red tape. There is a balance to be drawn, the government has to set the tone, as you just said. So we are setting the tone by saying we need to Freedom to Speak Up Guardians because it should encourage people to be open on all the things we have talked about.

We have tried to pitch it in such a way that it is a practical response that is of use to people in the organisations and it doesn't come with several thousand rules attached. There are other ways of getting things on people's agenda. So when the infection control was done, that was legislated for, actually, 10 years ago because we needed a blunt tool to say, "You have to stop this" and it worked. With Freedom to Speak Up Guardians

we've struck a balance of saying, "We need these people in the organisations, we have some infrastructure support, it can go back through CQC ultimately for reporting". But then we leave it to people's sensible discretion locally about how they take it forward by saying, "We don't want to see organisations that don't have those guardians in place and we expect them to be part of the fixtures of the organisation so that people don't forget that speaking up is important for a range of reasons, and it should be a typical part of how Trusts behave".

MS KARMY-JONES: Thank you. I think, William, you have to head off, so you are going to be replaced now by Mark Davies. If you want to do that now, that would be great.

Ursula, I think you had something you wanted to add and I want to move on to parents and children in a moment, to pick up on something --

MS GALLAGHER: Two questions. I was going to say something about examples and something about the national guardians office. Do you want me to do both of those, given time?

MS KARMY-JONES: Yes.

MS GALLAGHER: I think from our inspections as well as, obviously, excellent organisations like Alder Hey who

have been rated outstanding, there have been two or three things we have learnt. If I give a minute example, when we went into a general practice recently and we asked the reception staff about the chaperoning policy and what its purpose was, it was described to us as "to protect the GPs from false allegations". I think in microcosm that might explain the culture of an organisation that's got it a bit -- and I'm not blaming the reception staff, but that immediately for us, certainly as a trigger question, is a big trigger question into, we now need to do quite a deep dive here in terms of safeguarding, and I just thought that that would be the sort of example at the very extreme end of where this whole scenario can get quite muddled and I think it is where perpetrators such as Myles Bradbury can really have some stuff upon which to manipulate if they wish to have those sorts of conversations about what the context of this is.

As well as the great examples that Moya gave, I think it links with several things at the greater end of the spectrum around leadership. Certainly for us, it is those organisations we see that are really putting in systems at a more generic level but that are really important in terms of some of these issues. For example, the sorts of team building that gets into these

conversations about power relationships. It may or may not be and often isn't tagged under the safeguarding label, but it is about what they recognise around speaking up around a whole range of things, but also about what leads to great patient care. It is about use of things like 360 feedback in appraisal systems. It is about thinking realistically and creatively about supervision. Clarisser quite rightly spoke about the importance of clinical supervision, but actually it is not widely available and not all of our staff currently have access to clinical supervision and, in some ways, in some of those more vulnerable circumstances.

It is recognising of course that we do work in a busy system, but that actually where we have seen outpatients departments where not being able to provide a chaperone is recorded. Mostly it is about shortage of staff, but that is recorded.

We spoke yesterday about data helping to get into patterns. So if what you then picked up was a pattern where there was a single consultant who consistently seemed to be too busy to get chaperoning, and then it is how -- whether you want to call it professional curiosity, whether you want to call it professional scepticism, it is then the interrogation and the range of questions that that data gets asked, some of which

may absolutely legitimately be about, "Have we got the right staffing levels, are our clinical appointments organised properly? But isn't that interesting, that Dr So and so seems to be -- is he particularly disorganised and can we help with that or might there be something else going on?" You do see, not as much as we would like to, those examples around in the system.

We certainly find from our work, particularly in the organisations that we find to be outstanding, that there is a set of common characteristics about leadership that then are operating at a -- visibility but at generic levels, but that then impact on all areas of how the organisation thinks about their jobs. We have seen some amazing -- had some amazing conversations -- there was a great GP practice in Derbyshire, for example, where the way in which they had embedded with staff not only in terms of training, but in terms of enabling that whole range of staff to describe how their contribution to providing great care to children and young people, which included protecting them, and that had been made very live in terms of how the receptionists described what their job was, even how the cleaners described what their job was in terms of keeping the toys in the play area clean.

So those examples are there, and one of the things

clearly we hope to do through the work that we have published in our end-of-programme reports is be part of sharing that best practice and helping people to encourage that improvement. So there are great beacons but our concern continues to be the variation.

The final point, as William said, we host the National Guardians Office and I think, if they were here, they would say what won't be at all surprising, which is the Speak Up Guardians are operating best almost in those organisations at the moment that least need them because they have accepted them, embraced them and supported them because they are already open and transparent. The challenge for the National Guardians Office and for the CQC is to link those pieces of information up because there are also issues about organisations for whom those cultural and leadership issues aren't in the right place and, therefore, those Guardians themselves are less supported, more isolated. So it is those systems that the National Guardians Office is doing to provide some of that external support and leadership but that would be where they would say we are in that journey.

MS KARMY-JONES: To draw some stuff from that, if you can get that kind of 360 acceptance from everyone at every different level, even down to the cleaners, and involve

everyone in it, is it your view that that will also prevent or go some way to preventing disruption of teams and a culture of fear developing about being reported, because people will expect that that is a proper thing to do, that it is a proper way to approach things?

MS GALLAGHER: It is really interesting in those organisations when you talk to staff. The professional curiosity comes from a really positive place about, "How can we do better?" Because I think if the professional curiosity is only placed in the "That means I'm always suspicious", that's not the right thing, the professional curiosity is in the "How can we do better? What's happening? How are we working together?", and that creates that culture that helps to bring people together and to have that sense that the organisation is supporting them as a team and that sort of inverted governance approach, so it feels like the lines of accountability don't go upwards but they also go downwards for people to be able to legitimately ask of people, "This is what we need to do our job better" and that includes how we support and protect children and young people.

Discussion re parents and children

MS KARMY-JONES: I am going to move on to looking at children and parents in a little bit more detail. As

a general point, we have heard many times, and we have heard, and you will all have heard many times, of the great distress victims and survivors have experienced when their parents have continued to place them in the care of a hospital or another healthcare setting where they have been sexually abused, even though the parents may well have been acting in good faith.

I am just going to refer to one case, which was Robert Wells, who was a GP, in 1995. He was cleared of assaulting an 8-year-old and a 15-year-old girl. They were two separate trials at the Crown Court which collapsed following legal arguments.

At the time, no doubt because there were acquittals, the General Medical Council took no action. We don't have anyone from the GMC here today, so I make it clear, that, at the time, on the basis of the rules that they have, that was probably the decision that they had to take.

But despite the background, Dr Robert Wells was subsequently recruited as a police surgeon six years later, in 2001, to a regional police force, and that was even despite a neighbouring area force being aware of the earlier charges that had not been picked up by routine checks.

When it came to 2004, Robert Wells was jailed for 15 years, after being found guilty of nine charges of child sexual offences committed between 2002 and 2003, which included raping an 11-year-old girl twice and sexually assaulting her three times. The girl told the court that Wells had repeatedly raped her whilst she was in his care. He had also filmed himself attacking another 11-year-old girl as she slept after giving her tranquillisers.

He had a private practice in the south of England and also a flat in another area to the south of England where most of the attacks took place. At his sentencing hearing in 2004, the judge commented:

"You preyed on young girls and influenced their families, through your money and the status of your profession, to gain their trust and unsupervised access."

In 2017, this year, in April, Wells admitted four sexual assaults of three young girls which had also taken place in the 1980s in his GP surgery in Wales and he was sentenced to a further seven years in prison.

Another doctor, Ragupathy, a former GP at a practice in Catford, very briefly, he carried out his abuse of nine female patients -- some were adults, but the youngest was an 8-year-old -- by conducting unnecessary

physical examinations of patients' breasts and genitals. The abuse took place between 1995 and 2015, and he continued to practice until 2007, even though concerns were raised by one young patient's mother. Following his conviction, he was sentenced to two years' imprisonment -- sorry, I should have said 2005, not 2015. He was sentenced to two years' imprisonment, and following that, at a fitness to practise hearing, the General Medical Council erased him from its medical register in 2013.

So you can see the difficulties that there are with parents and children. One of the things I would like to explore is, what do we do, what do healthcare services do, to inform children and parents about what they should be expecting when they receive healthcare treatment so that they understand when something isn't right? Because they are not doctors. They may come from different cultural backgrounds. They may not speak English as well as the doctor does. So what is being done at the moment about that? Eustace, have you got anything you could help us with?

MR DE SOUSA: Yes. In 2011, the Department of Health launched something called "You're welcome" standards. These standards are directed at healthcare services and deliberately designed to encourage those services -- it

doesn't just have to be provided in a healthcare setting -- to be child- and young-person-friendly. So the organisation has to meet a range of criteria. The criteria, quite importantly, also then are assessed by young people themselves to see whether they meet the standards that they would expect to see.

So I think we feel that the "You're welcome" standards go a long way towards encouraging a culture in an organisation to be much more young-person-friendly.

It is really difficult, isn't it, for an adult, and even more so a child, entering into a clinical exchange, a clinical setting. You suddenly feel -- you can feel quite vulnerable in this context. I think what "You're welcome" tries to do is encourage the organisation to place the child and young person at the centre of that care episode and to be clearer about what that young person can expect in that clinical exchange and where to go to for help when something is not quite right. But it also equips the staff. I think it is a point that Moya was raising earlier. It is about sending a message across the organisation that, actually, we are putting the patient, in this case the young person, at the heart of everything that we do.

So the point that colleagues were raising, and actually others were raising, around whistleblowing,

et cetera, and critical questioning, actually we are looking at the position through something like "You're welcome", around continuous improvement, across the whole nature of healthcare, not just one particular episode around -- not just one particular area around safeguarding.

We are currently reviewing the "You're welcome" standard. As I say, they came out in 2011. And PHE is currently reviewing those with NHS England and we are due to submit a proposal to the Department of Health on the future of those standards and how they can be improved further in the light of some of the things we have heard today.

MS KARMY-JONES: Thank you. Vimal, do you have anything you can add from a general practitioner's point of view?

DR TIWARI: Partly from a general practitioner's point of view, but around the time that Eustace mentioned, around 2011, there were a series of publications which I think were funded by the Department of Health for preschool and very young children on what to expect when receiving healthcare, so what to expect when seeing a GP, what to expect when seeing a dentist, what to expect when being admitted into hospital. I believe there were videos that accompanied. They were very small, colourful books, which were intended to be widely available, and

they seem to have disappeared in the course of the health reforms.

I think it is really important that we continue trying to educate parents and children on what to expect, because going back to the examination of children, it is very interesting that you mention that Myles Bradbury was especially interested in puberty. With my other hat as a community paediatrician, the intimate examination of children is very rarely necessary. An assessment at puberty is done by observation, not by laying hands on the child.

The instances in which we actually have to examine a child by palpation are limited to children who are acutely ill. So I think it is important that that message is conveyed to parents and to children when they see a medical practitioner, and that they learn to understand what to expect and what is not to be expected and what is abnormal in that situation.

MS KARMY-JONES: I'm conscious of the time, and we are coming up for our break, so when we come back -- I am going to take some comments from the public gallery now, but when we come back, I would like to come back to this, how do we equip parents and carers and children with the knowledge to spot when something is not right, the ability to speak up? What do we actually need to do

about that?
Also, in relation to vulnerable people who have very specific needs, those who have learning difficulties, those from different ethnic backgrounds, who may have a different view of people in authority, for example, or a different cultural background. So if we can have a think about that over the break and we will come back to this question and then move on, please, to the recommendations in some of the reports and how well they are being covered.
But if I can turn to the public gallery.
Observations from the public gallery
MS TUCK: Just observations. People who work in organisations are normal people from society and most of us know that most of society feel that CSA is uncomfortable, they don't want to acknowledge it or talk about it. That is part of our problem, because people just want to close their eyes to it, and we really need to acknowledge that.
We need to also acknowledge that there is abuse in all organisations and this fact will be a very good starting point for organisations to take on board, just to acknowledge that it does happen and don't brush it under the carpet, bring it out into the open, because then you take away a bit of the sensationalism that

comes with it when you get a high-profile case.
When you do get a high-profile case, the reputation of organisations is damaged, and I think that is why a lot of stuff gets brushed under the carpet, because people don't want that reputational damage.
So if you have a culture of, "This is what happens when a child sexual abuse case has happened, this is our policies, this is our practices", and openly talk about it in your culture, this will bring about a change within your staff because staff are just society and society doesn't want to know about child sexual abuse.
So I think if you start making it a normal thing -- not normalise CSA, of course, but normalise the fact that, yes, we acknowledge it is there, yes, we acknowledge it happens and this is what we do about it, when you have a case, it won't get sensationalised because this is normal, everyday practice, as you said, from the top down, bottom up. Just change the whole way we deal with it and talk about it, really, is what I wanted to get across.
MEMBER OF THE PUBLIC: There are a couple of things I want to mention. I think Dr Chamberlain has already answered one of them. One of them is, when you do report it, can you trust the person you're reporting it to? So what Dr Chamberlain said is, they should get feedback on it.

Because we all know, in the past, where things have been passed to somebody and they have gone missing. An MP gave a load of documents to -- you know what I'm on about. They all went missing. So you have got that situation.
So they need to know that they can trust the person or they need to know that they are going to get some feedback on that.
The other thing is, in some institutions, they are now using lie detectors, you know, where finances are concerned. Our most valuable asset is our children. Surely, if something like this happens, if a doctor has been accused, why can't we use the lie detectors for that? I know they are not legal. But at least you can get some idea of what is going on, and I think if the doctor is innocent, he would gladly do it.
The other one is what one of the ladies said, if one of the nurses reports a doctor and that doctor is cleared, that doctor should not hold it against her. He should appreciate what she's done. Because I would. She's done the right thing.
MS KARMY-JONES: Thank you. I think, just in respect of lie detectors, there is sort of a mixture about how much they actually work and achieve and how much they can be relied on. So there is a bit of a difficulty with that.

Mr O'Mara?
MR O'MARA: Good morning. Nigel O'Mara, East Midlands Survivors. Two quick points. First, I would like to make a clarification of your opening remarks this morning. You said that people around the table have made individual responses. That is absolutely not true. All of the responses to this seminar have been submitted by organisations and it was specifically sent out to organisations, not to individuals, and no individual responses were asked for. That's all.
MS KARMY-JONES: I will come back to you on that.
MR O'MARA: Okay. I think the important thing is that we need to also recognise the effect of what's gone on before in the health system. There has been a culture of organisational protectionism over decades, and that has had an effect, and is still having an effect, where people have seen good people lose their jobs and be forced out of the system by doing the right thing in the past. I think making some form of clarity that those people who do speak up will get the right protection of their own position, and -- the problem is, with the NHS system, it is all based on teams. If you work within a team, closely within a team, it is very difficult to then accept that somebody within your team -- your team -- is able to do that. That's the culture that we

have got to get over, that separation between your team responsibility and your individual responsibility as a human being to protect children. Thank you.
MS KARMY-JONES: Thank you. Just in relation to your point, it is always good to be picked up and be made to clarify things, so thank you for that. The individuals who are around the table, most of the people here today and yesterday, represent organisations. Responses were provided by the organisations. My understanding is that some of the individuals around the table have had an input into the responses provided by the organisation that they represent and certainly they are aware of and agree with the content of the papers that we have received and that is one of the reasons why they are here today and yesterday. I hope that clarifies it for you.
MR O'MARA: Yes. I just wanted to clarify the difference between individual response and organisational response.
MS KARMY-JONES: Absolutely right. Thank you. Perhaps that is a good moment for a break.
THE CHAIR: Yes, thank you, Ms Karmy-Jones. We will return at 11.50 am.
(11.35 am)
(A short break)
(11.50 am)

Discussion re parents and children (continued)
MS KARMY-JONES: Welcome back. I am going to turn at the moment to Albert, who had something that he wanted to raise, I think.
MR HEANEY: Thank you very much. Albert Heaney, Director of Social Services and integration in Welsh Government. It does relate to the issues around parents and children. For a number of years, I worked in practice in the NSPCC, working directly supporting children and young people who had been sexually abused and also providing advocacy services to those children.
What was interesting, the parents and children often, within the health context, found the kind of experience of the hierarchical power, that hierarchical power can wrongly, on occasions, assume knowledge, and as entrants into the system, it was sometimes a challenging experience.
One of the issues that I think is clearly important, there is a changing culture, there is no doubt about that, professional curiosity conversations are happening, but I think they need to happen at different levels. So there is a professional curiosity about how we do business within our workplace, but there is also the professional curiosity about how we respond to parents' and children's complaints, their voice, how do

we keep it real, how do we make their voice heard?
I think that in this conversation it is important that we don't just look at it within a health context, but we look within health within a wider safeguarding perspective. So, for example, children's voice, how is it heard? I have been doing some work in a Welsh context around a national approach to advocacy, and one of the issues in relation to child protection is that we want to offer active offers to children so that children actually get contacted by an advocate so they don't have to reach out, they are reached out to. I think it is beginning to think about the kind of culture in terms of the way -- because if we look at it solely within, then of course we will deal with what we know and what we think we know, but if we widen that lens, we get a wider perspective. What I mean by that is being really true to include the voice of the child. That can be done in different ways. You asked earlier on about some of the solutions. You talked about children's speak-out groups. One of the groups I'm familiar with, indeed they have called themselves a shout-out group rather than a speak-out group because they want their voice to be heard.
There are different ways organisations can make themselves safer and be different arenas of safety in

terms of producing a different climate, a different culture. So it is that action of a professional curiosity not just being in terms of an individual practice, but wider, including the family and including children and young people themselves.
MS KARMY-JONES: Thank you. So responding to complaints and the voice of children, but how do we encourage them to understand they have got a voice? How do we encourage them to use a voice? Helen?
MS CHRISTODOULIDES: Thanks, Riel. So in our organisation, the first question you asked was, how do we let people know what to expect it might be like? So I was thinking of, we pass the information on in a variety of traditional ways, so there are leaflets and there is information on our intranet site. More innovative things we have done, so our children's hospital has a TV channel, and there is information on there about what to expect in a hospital. Our lead nurse for learning disabilities and autism and one of our transition nurses goes out to local schools, the special schools in Leeds, and invites children in and they will -- they thoroughly enjoy it and they get to experience a hospital environment and know what a blood pressure machine is and what might happen if somebody needs to take a blood sample. I'm proud that we do those things and that's

great. But I think that what we have to do is so much more. So when a parent or a child or any patient is sat at their bedside looking at a doctor or nurse and having an individual interaction or an adult patient, we have to start to change the dynamic of that conversation.

I was telling Simon that, in our hospital, in every ward, in every department, every month somebody else from another ward or department goes out and asks usually five patients five questions. One of the questions that I feel is very important is, "Were you involved as much as you want to be in decisions about your care and treatment?", and I happened to ask an adult ward, a female general medical ward was the ward I asked those questions on. But it was constantly -- perhaps not surprising, but disappointing to me that adult patients would quite often say, "Well, the doctor said this" or, "The nurse said that", and that wasn't the dynamic that we were trying to embed, and I would challenge that with the patients and say, "You can ask", and then I would help them with suggestions on ways to do that if they wanted to.

I would go back to their clinicians, the doctors and the nurses, and say, "You know, please can you ask patients what's important to them". I think they're the sorts of conversations we need to shift. So at the sort

of global level, we can show TV programmes and invite schools into hospital, but at the individual interaction level, we also have to support patients to be involved in their care.

A registrar came up to me the other week and said that she wanted to start an improvement initiative on one of the medical wards about asking patients what they wanted to achieve that day, "What do you want to happen today?", and she thought that we might be able to engender that everybody ask that of their patients. So I said that seems great.

There's a thing in the NHS initiative at the moment called "Always events", and I wondered, perhaps, if she couldn't use her thinking, what she was trying to embed in the "Always event" campaign. So, "We'll always do something. What will we always do? We will always ask you today what's important to you today and how can we ..." I just think it is those sort of conversations that involve people more that might start to help people understand that, you know, we are allowing them to be involved in their decisions and about care and their outcomes. So I think that's a way to go.

MS KARMY-JONES: Thank you. Can I just ask, following on from that, how much account is taken of the specific needs of particularly diverse groups of patients and

families? So transgender or LGBT, BME, how is that dealt with? Because the needs and the way you address things may need to be different.

MS CHRISTODOULIDES: I think it is challenging. I read, actually -- I think it was in "The Nursing Times" the other week -- a nurse was reflecting on the fact -- I think she worked in lung disease and she had to use an interpreter to help her with some care to a patient. There was no -- the word "breathlessness" she was trying to convey, and I can't remember the language, but the interpreter said, "There is no word in the language", the same I know that my lead nurses in older adults care, there is no word that translates for dementia into some languages. The closest you can get in some languages is "mad".

So it is difficult to take account of people's very specialised needs. We use things like hospital passports and care plans are written and made bespoke that then patients can take around with them so that somebody has thought through the specific -- reasonable adjustments, we call them. So what reasonable adjustments do we need to make to your care to ensure we are meeting your needs.

I'm seeing more and more of those documents in the hospital that describe to the next person involved in

that patient's care what reasonable adjustment has to be made, should be made, to enable that person to have a better outcome. So there are some practical things that we use.

MS KARMY-JONES: It's got to go beyond language, doesn't it, because it is not just the language that you use to speak to an individual. It has got to be giving the individual the language to speak back. How do we go about that? It is not just language, it is also culture. Because in some cultures it is very difficult, we all know, to stand up to someone who is perceived to be in authority. So someone who is a nurse or a doctor will be deemed as an authority and knowing what they are doing, and it will be very difficult for some to break out of that.

How do we give them the power -- first, the knowledge, and then the power, to do that. Eustace, do you have anything to add to this?

MR DE SOUSA: I think we touched on this briefly at the close of yesterday's session, the second session, and that's taking a much more rights-based approach around, "This is what I'm entitled to as a child/young person, as a patient", and being very clear about that. So clear about the expectations on what the clinical care would look like, but also how you would be treated.

I think Helen has made the point that this is much wider than CSA, child sexual abuse. I shouldn't think it's safeguarding, but just general -- care generally.

There are three levels that certainly we would see taking a rights-based approach. At a national level, NHS England have been very progressive in this -- sorry, I'm not speaking for NHS England, I'm here for public health, but we are working very closely with NHS England around the national youth forum. This is an organisation sponsored by NHS England, undertaken by the British Youth Council, I think, and provides a very safe space for young people to describe their experience of care, but, more than that, it is actually then to speak directly to national directors at NHS England to set out their fresh expectations of what the service should look like at a very strategic level. It is a very powerful influence, because they are speaking directly to national directors and describing their own experience of care, and we have heard some examples of those settings today and yesterday.

If you look at the second level, it is looking at individual Trusts. So I would argue more progressive Trusts -- this is drawing on my experience in the north-west in the previous role with Moya -- will actually have young people's panels where they are

actually shaping services, they are describing their experience of care in a safe place, they will have advocates where appropriate, and Trusts are then responding to that. So you find that particularly in Mental Health Trusts, for example, in CAMHS, but you will also find that in units providing large-scale paediatric care.

Then, at the third level, is the individual exchange of care, the interaction of care. Again, I won't repeat myself, but what I said earlier around the opportunities for "You're welcome" to make clear to the young person, and to their parent as well, what is age appropriate, "This is what you can expect. This is how you can expect us to treat you and this is the type of clinical care that we will offer to you and these are the choices that you have".

MS KARMY-JONES: Does the health sector engage in the development of sex education at all? Let me start with you, Eustace?

MR DE SOUSA: Yes, is the short answer. I think at the moment, as colleagues will know, the government have committed to introducing relationships education in all primary schools, from, I think, as soon as 2019, and in secondary schools to introduce statutory relationships and sex education.

MS KARMY-JONES: Could that be developed more so that it supports children to understand what's appropriate in the healthcare setting?

MR DE SOUSA: I think it will provide children and young people with an opportunity to understand what's appropriate in any setting and they can apply that in a healthcare setting as well. So my understanding is that the Department for Education is currently out for consultation on the content of both relationships education in primary schools and RSE, relationships and sex education, in schools.

MS KARMY-JONES: It might be a difficult thing for a child to apply it if they have a parent saying, "You can trust your doctor, your GP, your nurse, your surgeon". Does it go beyond the, "If an adult does this to you, it is wrong", as far as you're aware?

MR DE SOUSA: I can't comment on the detail because I think that's still being worked out by the Department for Education, but certainly in our submission to the Education Select Committee, we have been clear that, actually, we should be looking at this in a wider context, not just in individual settings. It is about equipping children and young people with the skills to understand what a good relationship looks like, whether that is a personal relationship or a professional one,

one from a professional.

MS KARMY-JONES: Thank you. Moya? I am going to go along the row.

MS SUTTON: A number of years ago, I led a revolution in Alder Hey. It was something that I was particularly proud of in terms of the fact that we became the first health-promoting hospital for paediatrics in the country, and were recognised for it. The reason why I felt it was important to do that was (a) because my chief executive said, "Put your stamp on this place very quickly and own something nobody else has done", and I happened to manage children's social services before I became the executive nurse at Alder Hey and was really interested in the health needs for looked-after children, especially their sexual health needs and their emotional health needs. So I transferred that thinking and leadership to the hospital. I actually think, in a clinical setting, you have got such a wonderful opportunity to look at the health of the child and the family within the family setting, be it dental health, sexual health, emotional health, dietary health, et cetera, et cetera. Because we know, don't we, that children who have been sexually abused, many other clinical issues emerge -- self-harm, bulimia, anorexia, et cetera, et cetera, et cetera. So I think there is

a wonderful opportunity for us to encourage, perhaps through NHS Improvement and the CQC, hospitals to think about their health-promoting potential and especially look at doing something specifically around children and getting children and young people to engage in the development of those standards, for want of a better word.

I think it is really challenging, because I think, when we talk about youth forums, young people's forums, young people's councils, we are talking of an age group at the older end of the spectrum, and yet there is something really phenomenally important about working with tiny tots and using different mediums to get their involvement in terms of their thoughts, their expectations, their voice, whatever that voice might look like.

I know the NSPCC have done some magnificent work, Barnardos have done some magnificent work. I think we need to work as a much better collective in terms of getting some of that good practice across the system generally.

MS KARMY-JONES: Geoff, I think you had something you wanted to add?

DR DEBELLE: I think you have put your finger right on it. Something has been bothering me all morning. It is

probably me, not the college that I represent. But I was thinking, I can understand with health education how you can teach, or try to teach, a young person what they should do if they feel uncomfortable with an adult approaching them, but when I think of a mother bringing her child to see -- to a clinic to see me or my co-paediatricians, they should have a right not to expect anything other than perfect care. There seems to be something wrong -- is there something with our society that, why is it -- are we on a -- I don't know how to express this, but why are we expecting parents to think anything bad about a consultation that they are going to have with somebody that's supposed to be looking after their care and interests.

MS KARMY-JONES: That absolutely comes into another question that I have, and it ties in with something that William said earlier: how do we ensure that encouraging children and parents to feel able to speak up and giving them all this education doesn't detract from, in fact, the responsibility of the staff to detect and respond to concerns? Shouldn't it be the staff, not -- are we swapping the onus, are we putting the onus on the wrong people by doing this, because shouldn't parents and children be able to go and not fear that something might happen?

DR DEBELLE: Yes.

MR DAVIES: Just to follow up on that, I think there is a way of bringing this together. I was listening to what Helen said about the relationship between a healthcare professional and the individual they are caring for, the child they are caring for, and then thinking about the -- you mentioned the role of sex education and the work that's developing there. It feels to me you need to get the balance right. You need to both empower young people, and part of the sex education developments there will be about building resilience in children. So knowing what to expect and how other people relate to themselves and, in particular, their own bodies.

Then there is something about the fact that Eustace mentioned earlier the "You're welcome" standards which we will be looking at and thinking about how that framework supports that relationship between more empowered professionals and more empowered young people, and giving advice to young people about what they can expect is a really -- I think a really important element of this. I think it feels to me there is a way of bringing it together which actually triangulates the professional role and the empowerment of parents and young people, and that's something I think Eustace and

I were talking about in the break, about how we can go and use that to start to think about developing the "You're welcome" standards and other standards.

MS KARMY-JONES: What we want to get to is what that way actually is?

MR DAVIES: Yes.

MS KARMY-JONES: I appreciate there is work to be done and it is very useful that people will come together and talk about it. But what is it? Can anyone suggest anything more specific that will happen the chair and the panel come to views and recommendations in due course? Let me see if I can turn to Ray?

MR McMORROW: One thing I feel that's been absent over the last couple of days is the level to which healthcare engagement is on the social media world. I think sitting on a board with a family nurse partnership project, I recall when a young couple came in and they asked how they'd engage with the FNP. They said, "Well, the nurse came to see me and suggested we go on the programme, and we then went on to the internet to find out who they were, what the project was about and we looked to see if there were young people like us on the voices." These are parents. I think we need to remember that, you know, parents now are of a digital generation -- in fact, we all are, to some degree, but

the reality is that many of the tests of "Is my voice going to be heard there?" take place before they get to your front door. Even if they actually get to your front door at all, because, in fact, some of the work may actually be done within that social media context.

What's really important is how health communities place their footprint within the social media in a way that young people -- I'm referring to parents here as young people, being old enough to do that -- will engage with health and that's where I see the rights-based approach being critical, and we see that often in Europe to much more effect, that you go there knowing what your rights are. There is nothing about disrespectful towards professionals and what you expect of professionals, but it is almost how they expect your voice to be heard, how you can -- most good doctors now find out what the -- you know, of the condition from what you have looked online already and assume those things, but there is also, what have you learnt about what we do? It is really important, I think, that we really work on those areas. That's what I want to see, what we can do to actually create online a system that ensures people come feeling empowered that they can protect themselves. Actually, that gives a voice, sort of what Geoff touched on there, not just to those

parents, but it actually gives a voice to what might be seen as junior staff as well, because they're responding to that offer as well. So it's the offer from the organisation which can be owned as a culture within that organisation that starts to dismiss that hierarchical approach.

MS KARMY-JONES: Thank you. Ursula?

MS GALLAGHER: I'm going to try not to take us too far back to take us forward, but building on some of these conversations about questions and how some of these things might be developed, we certainly have found in a number of the places that we have inspected, including child and adolescent mental health units in some of our work in secure children's homes, that two questions that are often found to be very useful are to ask the child or young person, "Has anything happened today or in the last 24 hours that made you feel unsafe? Has anything happened that you didn't understand or hadn't anticipated, that you weren't expecting to happen?", and of course a whole range of issues -- those are very powerful questions, and they can be quite powerful too, because we've talked about some of the protection issues with respect to health staff, but also, in some of those environments, children and young people can be vulnerable to other patients or service users and they

can be vulnerable to visitors and a wider cohort of people.

Those are often -- those have been found to be quite helpful questions, and really giving that space and permission for children and young people, and that sense of, "They're asking me, so they may really want me to tell them," which I think can be quite important.

I think the second thing is, both through the education curriculum, but some of the services that are now commissioned through local authorities and public health, particularly school nursing services, I think Moya, from our profession, we would talk about every encounter being a health education or health promotion opportunity, and I think in this space we should think about also thinking that every encounter with a child or young person, whether through classroom teaching, an individual encounter, perhaps, perhaps in a school, or any therapeutic encounter, is an opportunity to give some space to put a crack in that door to allow the child or young person to -- and to feel that there is time for them to talk broader than just, "I have come because I have fallen over in the playground and my knee hurts". Again, often, services that are doing this well have -- give open an opportunity about, "Is there anything else you would like to talk about? Do you

think this was caused by anything else that perhaps you haven't been able to talk about?", and to make those expectations, as many of them do, through information to parents and others, that "This will be talked about", and again that opportunity then to involve the parents in what's happened around those conversations and the feedback and the connection with schools.

MS KARMY-JONES: Thank you very much. Angela? Can I call on you, please?

MS HORSLEY: Thank you. I just wanted to sort of raise something in relation to things that have been mentioned earlier, really. Moya mentioned the health-promoting hospital. Eustace mentioned the "You're welcome" and also youth panels. Quite often, those things occur or happen in larger children's services.

So my concern in some respects is, what about, you know, that one children's ward in a big district general hospital and how is the voice of the child or the voice of the parent or advocacy on the board replicated there?

MS KARMY-JONES: Thank you. Clarisser?

MS CUPID: I just wanted to touch on what Ray said earlier about social media. One of the things is that we talk a lot about listening to the voice of the child, but do we act on what they actually tell us?

In the area where I work, we have a terrific group

of young people called "The Change Makers", and they do a lot of work on the behalf of the Safeguarding Board, including health, as part of that. They did a piece of work around going and asking other young people about what they want from health, what they want from agencies, from professionals, and they created this -- what we call "The children's charter". So it is a local charter identifying quite clearly what children and young people want from professionals, and what they are saying quite clearly is that they want to be listened to, they don't want to be just taken as a patient, a client, they want continuity of care, they want whatever they say that we listen, but we also act on it and it is very important.

The other thing around the social platform is the fact that, when they fed back, well, actually, we are on a completely different platform to communicating with them, because we are still there and they are already there (indicating), and by the time we learn what they are working on, they have already moved on to something else.

In health, we have got to move faster to engage young people. Even going to a simple GP appointment, how engaged do you find young people going? What young people are saying to me at work is that, actually, they

don't. They will go online and they will access what services they can online. So therefore, even though we are listening to young people, we are not exactly seeing them so we can listen to them.

In terms of children, obviously that's something complete different. We have to find ways of engaging with children at a very early stage so they can tell us their story as well and that we can act on that. Thank you.

MS KARMY-JONES: Thank you very much. It ties in a little bit with something that was said in one of the videos, doesn't it, because one of the videos we saw today, the point was made that in psychiatric care there was such an emphasis on treating what was wrong with the child, but not any enquiry into what might be happening with them. So even if there isn't a voice, sometimes there may be an overemphasis on just doing the treatment rather than maybe investigating further. Does that resonate?

MS CUPID: Definitely. One of the things we also have to remember is about training staff. Staff, or I should say nurses, are trained to deliver care. We are trained to speak to patients about their procedures. Are we trained to speak to them about what's happening within their lives? I think a lot of staff probably are,

because we have moved a way ahead in terms of safeguarding training. However, there are opportunities, and we will see that from many serious case reviews, that opportunities are missed, and it is about staff being aware or being able to use those opportunities when they do come up to speak to young people, but also pick up on those cues. We get the cues. Are we too busy to see it or do we find the time to pick up on those cues and explore a bit more, to find out exactly what is happening with this child or young person?

MS KARMY-JONES: Thank you. Rhiannon, do you have anything you can help us with?

MS BEAUMONT-WOOD: Yes, just to share that very recently, actually, our Children's Commissioner In Wales has written to all chief executives in the NHS asking organisations to assess themselves from a rights-based -- a children's rights-based approach in terms of health settings contexts, and obviously that pushes up the agenda the need to be much more visible around making organisations contextualise themselves, if you like, that this is a children's right-based space that families, children, communities, et cetera, are engaging and involving. So that's one point.

The other point I wanted to make, a big piece of

work that's being rolled out, really, and really with the aim across public services in Wales, is around the whole adverse childhood experiences which I think somebody referred to -- I think it was probably Simon -- yesterday, but that is in part about how we learn from adults, because we talked yesterday about the lack of knowledge around prevalence, so actually understanding -- so adverse childhood experiences, it would be about public services and people working in them routinely inquiring with adults about their experiences that were adverse in their childhood, of which obviously abuse is part.

Of course, survivors groups are also a rich source of learning for us to understand where we can improve, but I think we could get some quite interesting additional information around understanding areas to improve and prevalence from some of this adverse childhood experience approach.

So the idea we all become ACE informed. The point that the lady from the public gallery there made around society normalising that it is a thing that happens in society and, therefore, it is something we should understand better, and the way we do that is to actually talk about it. So that was a couple of the points I wanted to share.

MS KARMY-JONES: Thank you. Ursula?
MS GALLAGHER: I just think it is important to pick up this discussion about what's going on in the digital space. As somebody who is not even on Facebook, this is a very bad place for me to be, but there we are.

The CQC has been quite concerned about what's happening in particularly the digital healthcare space and has just completed a whole round of inspections on all of these providers, and issues in relation to safeguarding have come up.

If you think about things that are purely being done by online questionnaires, a whole set of issues around identification, a lack of awareness by many providers about both what their safeguarding responsibilities and duties are but also unconnected into local systems properly in terms of them being able to access advice and support from professionals.

Clearly, we have taken that, as I said, very seriously and have taken regulatory action against some of those providers, but I think we have also been concerned particularly with the identification issues that it could be an opportunity for grooms and others to be able to access contraception or treatment for sexually transmitted infections without necessarily it being the actual patient online. So there are huge

opportunities in digital space for access, there are huge opportunities around communication, but I think it is going to be a real part of this challenge, that I know our Secretary of State is also interested in, about the sorts of things we need to educate children and young people about, how to be safe in some of these media, and healthcare services is one of those areas.

Discussion re culture and leadership

MS KARMY-JONES: Thank you. All right. I would like to move on, if I may, unless there is anything anyone pressingly wants to add to the parent/children issue before we move on, to fostering effective safeguarding culture and leadership and to the recommendations that have been made by some of the investigations. I'm sure that those sitting around the table are familiar with them. We have just drawn out a couple of points, and I would like to get your feedback, please, on whether recommendations are being followed and how effectively they are being followed.

So, for example, the Lampard Savile recommendations, recommendations that were made to the whole of the NHS. I won't go through all of them, but amongst them are that all NHS Hospital Trusts should develop a policy for agreeing and managing visits by celebrities and VIPs and other official visitors; there are recommendations that

voluntary service arrangements should be reviewed, ensure they are fit for purpose. Really, treating volunteers in the same way as staff.

There are recommendations that staff and volunteers undergo formal training in safeguarding at an appropriate level at least every three years. Query whether three years is in fact enough.

There are recommendations that safeguarding resources, structures and processes be subjected to regular reviews, as should be the behaviours and responsiveness of management and staff.

There are also calls for NHS Hospital Trusts to ensure that arrangements and recruitment checking and general employment and training of contract and agency staff are consistent with internal HR processes and standards, and also to check the consistency of HR across departments within Trusts.

The Care Quality Commission and the NHS should exercise their powers so that Trusts, Hospital Trusts, comply with the recommendations.

So how much are these recommendations from this inquiry actually being followed? Moya?
MS SUTTON: So William, who left earlier, on the back of the publication of the first Lampard Report, called together a number of key partners. I represented

NHS England, CQC were represented, the Department of Health was represented and NHS employers were represented. It was our role to ensure that the recommendations that were applicable to each of us were developed into a sort of localised action plan and that we then put into place monitoring arrangements.

For NHS England, we asked our regional quality surveillance groups to actually performance manage the implementation of recommendations, and the reason why we suggested that was the right place to be was that around that table there were the commissioners, CCGs, providers and the regulators at a regional level.

We were asked, I think it was about a year ago, I think Kate Lampard wrote to the Secretary of State and asked how much progress has been made, and I think it is fair to say, in some areas, significant progress has been made, but in other areas, not so much progress has been made.

I think I would come back to say that, if I can specifically talk about the training that you raised, that was really clear in the Savile investigation, that some staff were trained, some staff weren't trained. There is no excuse for it. The Royal Colleges have recently reviewed the intercollegiate guidance for training, safeguarding children and young people, and

they have changed some of the levels. Level 6 used to be for expert witnesses. Level 6 now is about executive leadership, because prior to the change of that level, the only expectation of boards to have safeguarding training was at level 1, which is basic awareness.

Intercollegiate guidance is very clear that it sets out all the competencies required at level 1, which is everybody. Level 2, those who have a greater connectivity with vulnerable individuals, children and young people. Level 3, for those that are outward facing, so midwives, A&E, CAMHS, interagency working. Level 4 for the named professionals. Level 5 for the designated professionals. And level 6 for the executives.

So everybody should be accessing that training. I think one of the issues is that boards need to get tougher in performance managing the level of training, and certainly my experience is that, quarterly, the HR director would present how much mandatory and statutory training has been undertaken, and certainly in NHS England, I can put my hand up, you get hunted down if you haven't done your mandatory training. You are on a list, and you have until Christmas Eve to do it. So we all panic on the day before Christmas Eve.

But if a board performance manages properly and the

regulators inspect against the intercollegiate guidance and the intercollegiate guidance is interactive and creative and allows for peer supervision and other things to happen around scenarios, then there is no excuse for it.

So the tools are there. It is how those tools are being used and how effective they are.

Now, I have to say that, in some organisations, you can do your safeguarding training online. How effective is that, really?

MS KARMY-JONES: How are the checks made?

MS SUTTON: Well, that is the issue. That is what was found in the Savile investigation.

I don't see the need for the training just to be done every three years. I think that there are other ways, through supervision and through scenario-based thinking and interagency working, where you can actually further develop and enhance your skill set around safeguarding.

Level 6, I have to say, NHS England -- and Vimal has been brilliant with me working on this -- funded a programme for executive leaders, about 500 chief nurses, chairs of CCGs, providers, directors of nursing were invited to undertake an executive leadership programme with a fantastic barrister that frightened the

life out of them all. We funded a programme for designated professionals who are the clinical experts, and so important to the work of safeguarding, and then Vimal helped devise and design a training programme for named GPs at level 4.

So we have actually got some fantastic tools that we have commissioned and paid for that we could recommission over the coming months or we could be encouraging our Trusts to commission them on a locality footprint.

MS KARMY-JONES: On a practical level, speaking of levels, for example, something we touched on yesterday, the training of, say, staff who may often be temporary staff, and when you are talking about level 1 training and that sort of thing, it may well be built into a contract that they should have completed, potentially online, their level 1 training, but how are those matters checked when staff may be coming and going and changing and there is a lack of consistency with them?

MS SUTTON: I think it is a fair question and a very challenging question, but I think that if your board and your organisation holds safeguarding dear to its heart, there is no excuse for nobody not to have that training. I think the comment you have made about volunteers is so well made, so well made, and NHS England are trying to

work with the volunteer councils to try to really strengthen the management of volunteer teams, the training of volunteer teams, because volunteers now are a huge part of most provider organisations and should be treated with the same respect in terms of their proper DBS checking, to begin with, referencing and also training and supervision and support as required.

MS KARMY-JONES: Yes, Geoff?

DR DEBELLE: You may be coming to this later on when you are discussing the Cambridge inquiry, but they made a point that within the current safeguarding training, there is a sort of lack of a safe environment where people can discuss some of the things we have been talking about today, and they also recommend that the Royal Colleges look into a national curriculum for training, because training -- even though the intercollegiate document sets out the competencies required at various levels, you can do basically what you like. Some do it online, some do it face to face, some both. In each Trust you go to, there is probably a different training curriculum for level 3, for example, whereas the Cambridge inquiry was suggesting the colleges develop a national curriculum, both at undergraduate and post gradate level, which is something I have to say we haven't moved forward on a great deal, but there is work being done in

that area.
MS KARMY-JONES: That's the distinction -- we touched on this yesterday -- between education and training. There is onsite training and then there is a deeper level of education potentially. I think that is what you are really referencing.
DR DEBELLE: Yes. Some of the things we have been talking about, about how to pick up the non-verbal cues, for example, with children and young people who are being abused. I was talking to some of the people in the public gallery, survivors, and they say survivor groups have got a wealth of information about that very topic and they should be embedded in training as well.
MS KARMY-JONES: Yes. Just because you have mentioned the Bradbury report, I am just going to reference a couple of things from that. Obviously, the recommendations from the investigation following the Myles Bradbury case were recommendations that were specific to the Trust, but there were two learnings from the Bradbury report that it might be reasonable -- I think Sue, who was here yesterday from NHS, that it might be reasonable to expect the NHS or any Trust or any relevant healthcare provider to take on board -- possibly three.
Firstly, that the chaperone policies should be reviewed and really there should be some consistency.

I think one of the things that was said yesterday was that, if there is an intimate examination or -- what comes under this is, if there is an intimate examination, a formal trained chaperone should be present. If it is a non-intimate physical examination of a child, an informal chaperone could be present. That could be a parent or carer. That comes under the Cambridge University Hospital Trust guidance.
Then there should be a review to identify unusual patterns of treatment by individuals that require further investigation. So a review to spot things that raise concerns to keep the records and the data so that -- this, again, was something that was touched on yesterday -- if it is raised more than once, perhaps, something is done about it or an enquiry is made.
And that the Trust should invite NHS England to consult on creating guidance on the areas to be covered and the principles to be reflected in chaperone policies.
Actually, I am going to ask Ursula, I think you had something you wanted to say about the previous conversation, but can you tie --
MS GALLAGHER: I was actually going to, because it will pick up the chaperone discussions as well. Obviously, we, as one of the system regulators, have a significant role to

play in this area. We have just been developing our next phase methodology. We strengthened our questioning and oversights for both executive leads and all levels of organisation across all of these governance areas, including oversight volunteers, celebrities, other groups mentioned by Lampard.
We have picked up all of the specific recommendations, issues in relation to a chaperoning policy. We have just commenced those inspections, so it is hard to say at this point, but we will start being able to provide data and will certainly be taking regulatory and enforcement action, should that be required.
Two or three other things I wanted to say. I think, as we said yesterday, clearly, the challenge for us is to have that conversation in the context of assessing an overall system. You can have everybody trained, but it still won't work. You know, so our conversations are then -- linking that, particularly at a clinical team care setting, ward-to-board level -- all of those questions about, how do you know it is working, how do you know what difference it is making, how are you monitoring what is happening, what might you have expected to happen, are you hoping that causes for concern will go up with this training, have you

evaluated the training more than at some of those various superficial levels?
Again, our not anecdotal evidence but our evidence would again say that, unsurprisingly, the organisations that get it, alongside lots of other things, are embracing some of this agenda and making quite a lot of difference and asking themselves the right questions. The critical issue is, what are the questions the organisations need to be asking themselves and what are they doing with those answers?
Even with the new guidance, it still causes some concern to me that the most common -- in the safeguarding space, there are two or three common areas of dispute between us and providers, and one of those is about local interpretation of levels of training. I don't have a -- I am open to local interpretations, but what I want to see is the narrative and the risk assessment, not a conversation called, "I don't know how I am going to hit the target. I don't have enough time to train everybody to level 3 because that would take away so much clinical time". It is about, what are your clinical models, what are your supervisory arrangements that are in place?
I briefly mentioned the independent sector yesterday. Clearly, there is a challenge for us -- we

are often challenged by the independent sector about the extent to which these NHS rules and regulations apply to us and working together is often an interesting discussion in that space. I have to say, we take a pretty robust view, but I think it is important to mention the independent sector, particularly, again, in some of the things that haven't come up in the conversation, but we are concerned about them, for example, in the context of things like modern slavery. So there will be some of those populations and sub-populations who won't be eligible to access NHS services or, again, where people are deliberately taking particularly vulnerable people out of the NHS because, despite the concerns we may have expressed, you are very much more isolated if you are in some of these situations in the independent sector, and we are out -- my colleagues at the DH are out to consultation at the moment to strengthen particularly our powers to rate in the independent sector, and I think that that will be very helpful, I think, again, to service users or the NHS who are considering commissioning from independent sector services that we can create a much more level playing field.

MS KARMY-JONES: Thank you very much. Can I just bring in Simon on this briefly, just because it reminds me

important.

The role of the system, in sort of government terms, particularly, is to set frameworks, but I think it is then the responsibility of employing organisations to be ensuring that those are implemented.

So I come back to your comment that I quoted earlier: we all know what needs to happen; why doesn't it happen? That's an implementation issue, that's a delivery issue. I suppose, if I change that question, it is, do we need more policy? Do we need different legislation? Or is it about effectively implementing what we already have and what we already know? If that is a view that's shared, then that is critically the delivery space, which does bring the role of the delivery organisation and the role of the employers into sharp relief.

Clearly, we have an interest, as a government department, in making sure that the frameworks are appropriate and that they are complied with, and the regulator's role is to assist in how -- the HRW rather than the GMC type regulatory role at the moment is to help form a view about whether those policies and frameworks are being applied across the system as a whole.

I find it quite interesting, in this gathering,

a little bit that yesterday -- I don't want to misquote you -- one of the things that you were advocating was that responsibility must fall on the individual organisations, and there may be a conflict between what's being said here, because, if it falls on the individual organisation, doesn't that cause the problem that Ursula -- couldn't it cause the problem that Ursula has potentially highlighted about needing consistency and an overview between organisations in terms of the levels applied?

MR DEAN: I think responsibility resides in a number of different levels. I think a colleague who was here yesterday talked about three lines of defence. I think she said, "I'd perhaps add a fourth". So she talked about the individual. The one I would add is the team, and we've talked about that and how the teams work together in a way that is appropriately vigilant. Then there is an organisational level and I think it is a system level. I think we need responsibility to be enacted at each of those levels, not one or the other. So we touched yesterday on the role of the regulators, and the role of the regulators is largely after the event. We talked about the importance of individuals exhibiting proper values and proper professional standards in their practice, which is critically

there is probably only one person around the table today and yesterday who is at a corporate provider level, and that's Helen. I think you might find it quite interesting to talk to a group of chief executives, for example, about their view of the world or perhaps some chairs of NHS organisations to see what it feels like from their perspective, because that's a critical part of the system that certainly, from where I sit in a government department, can provide that level of confidence and assurance in the way that Moya was talking about earlier, about how the board in that particular Trust chose to behave.

We can set frameworks, we can set expectations. We don't run delivery organisations. So responsibility resides at all levels in the system, and it is important that it's exercised appropriately at all levels of the system. It is not just about employers, it is not just about individuals. It is about how the whole system works together effectively.

MS KARMY-JONES: I was in fact going to turn to Helen for your perspective on whether you actually see the recommendations -- has there been a change? Do you see the recommendations being put into effect?

MS CHRISTODOULIDES: Yes. I'm clearly only representing my organisation, but absolutely. I mean, I think I said

yesterday about the volunteer process and the fact that our volunteers are now subject to the same NHS employment checks as substantive staff. That is having a knock-on effect in terms of recruiting volunteers. I'm not suggesting we change it but, for a variety of reasons, we are not recruiting as many volunteers as I would like, as our board would like, because people don't always have the ability to get references to the standard and don't have term-time addresses with utility bills, and so on, and so on.

Our training has been -- we have implemented the recommendations from the intercollegiate document. It was a huge piece of work. I hear what Ursula is saying, you know, there is no excuse, but delivering that face-to-face training across our large organisation is taking a lot of time of our safeguarding team, but we are committed to doing it, we will do it. We have a policy for visitors and a nurse said to me the other day -- she wanted to get a group of Brownies or Girl Guides in to sing on an older adults' ward, and I thought that sounded lovely, but anyway, she said, "Oh, I can't even do that now", and so obviously I said, "Of course you can", but, you know, it is interesting how people feel the implementation of these recommendations that are there to safeguard, but, you

know, people do have a slightly mixed message about what that means. But, yes, they are being implemented in our organisation certainly, yes.

MS KARMY-JONES: So, again, there is that question of, can there be too much red tape?

MS CHRISTODOULIDES: Well, I think the staff do perceive that there is too much red tape, yes. And it is that balance. You know, I don't know the answer, but I think that example is --

MS KARMY-JONES: Do you think the red tape may discourage people from coming into the profession, people who are good and are exactly the kind of people who really everyone around this table would want in a safeguarding role? Would it discourage people?

MS CHRISTODOULIDES: To work as a substantive member of staff? Possibly not, because I don't think you appreciate it until you get there, really. So perhaps not. But it is a real frustration. You know, in the NHS, we talk about workarounds and that we are very good at working around things to make it work, and in our hospital we are doing a big programme of improvement linked with some other Trusts in the UK, linked to Virginia Mason and learning from their work around lean and productivity and efficiency. So we are having a critical look at processes and, you know, you might

call it some red tape, to try to enable people to do their jobs and in fact next week is "Perfect week" in our organisation, which is linked with patient flow, but it is about efficiency and productivity.

So we are constantly trying to improve and to support people to do their jobs, to improve patient care and outcomes in the context of some things that staff don't always perceive are helpful.

MS KARMY-JONES: Thank you. Now, I see the time. We are under the clock. So I am going to briefly go to the public gallery, if I may, and see if there are any observations or comments from the public gallery, after which I will just tie up and hand back to the chair.

Observations from the public gallery

MS TUCK: So some of my VSCP colleagues have been watching the live stream. One of the questions was:

"Professional Standards Authority refers to the duty of candour regulation and notes with disappointment that they have not seen it reflected in allegations against registrants. What impact might mandatory reporting have on this?"

So you might not have the answer today, but it is just a question.

Another one:

"It seems that there is a greater awareness of

issues around domestic violence and the policies about domestic violence are easier to implement. What can we learn from this to improve implementation of policies around child sexual abuse?

"A submission from Professional Standards Authority says that someone who is convicted of a child sexual offence is usually struck off but this is not always. What is the criteria for striking someone off or not? What does this mean, 'to be struck off'? Do the public understand what this actually means?"

From my point of view, from the parent/child intervention or being able to speak up, when you go to your doctors, you only get ten minutes to speak to that doctor. There is not often continuity of care because you see a different practitioner every time. If you have gone through child sexual abuse, or any abuse, you need time to build trust and rapport with the health practitioner. For that health practitioner to notice any differences, you need that continuity of care. So how do we make that happen when we have got time restrictions, when we have got resource restrictions, and even in the hospital settings or other care settings, staff need the time to do their training, and we have got budgetary restrictions all over the place, so how do we make anything that we are going to

implement, how do we make it happen if the finance ain't there and if the manpower is not there?
MEMBER OF THE PUBLIC: Let me introduce myself. I am Tom. I was in the Castle School, Stanhope, County Durham, an approved school, in the early 70s. I will read this because I lack self-esteem.
MS KARMY-JONES: Can I just check with you, first of all. We have a rule about not mentioning names of places.
MEMBER OF THE PUBLIC: Sorry, I forgot what you said.
MS KARMY-JONES: Just because it might intrude on other allegations. Are you content for whatever you have to say to go into the public domain? Because we can cut the video feed.
MEMBER OF THE PUBLIC: Absolutely, yes.
MS KARMY-JONES: Can I ask you not to mention specific names then for us? Thank you very much.
MEMBER OF THE PUBLIC: There are two Toms in me, in my life: the successful adult with a career, wife, three beautiful children, two dogs and a lovely home; there is also the Tom who was abused in care. I managed to get my Social Services records. There was a psychiatrist report when I was in an assessment centre. The psychiatrist recorded me as being "retarded". When I read this report, I said to my wife, Trisha, "Am I retarded, darling?", "Of course you're not, Tom".

The doctor said I was retarded as a child, that I had withdrawn because of sadistic, mental, physical abuse. I would be shocked if medical professionals still lacked care and understanding for children in care. Thank you.
MS KARMY-JONES: Thank you very much, Tom, for that. That's an incredibly brave thing for you to have done, and thank you for sharing that with us, particularly at this point. It rounds off what we are talking about beautifully, and it is very kind and very brave of you to share that with us. Thank you.
Mr O'Mara, did you want to add something?
MR O'MARA: Yes. I just wanted to round off by thanking everybody, as a survivor, for coming today and yesterday and for your contributions, and also to acknowledge to the panel for the inclusion within the agenda of the amount of time for the public gallery. It is something that was very important to me. Thank you.
MS KARMY-JONES: Thank you. Thank you for that.
Just to round off, I think what Tom has told us is very relevant and, as I have said, we are very grateful for all of that. There is an emphasis, isn't there, that this goes beyond doctors, it goes beyond hospital practitioners. I just wanted to bring to your attention two cases involving nurses.

A nurse called Oliver Balicao, I think it is, was, in 2010, convicted of the rape of a teenager in a side room. It took place after the teenager had been rushed to hospital following an overdose in 2004. The background to that case, though, was that that nurse, the same nurse, had been jailed three years before in 2007 for 16 months for having sex with a 16-year-old patient in a disabled toilet at the hospital after she had overdosed on paracetamol. The offender had been accused of raping that girl when luring her in saying she had to do a urine test, but he was cleared of that and there was a guilty plea to sexual activity with a child whilst in a position of trust, yet somehow he managed to come back into a nursing situation. The offences took place between 2002 and 2004.
Another one, a man called Andrew Hutchinson, was convicted of raping two women, one aged 18 and one 35, but also sexually assaulting and spying on female patients, including some who were unconscious. He also used a camera to spy on women and children, the youngest of whom was 9 years old, at a leisure centre. Those offences took place between 2011 and 2013. So it really does have to be remembered that we are not just talking about historic offences, we are talking about things that are happening now.

Again, can I express thanks from all of us for everyone's attendance here and contribution and the work that has gone into the preparation of this. As I said at the outset, this isn't an evidence-gathering process, but everything that has been said I am sure will be borne in mind by the inquiry and will assist as background as and when matters are, in relation to individual case studies and investigations, considered and, at that stage, when recommendations in respect of those are made.
So thank you, again, and may I hand back to you, chair.
Closing remarks by THE CHAIR
THE CHAIR: Thank you, Ms Karmy-Jones. Thank you, more particularly, to yourself and to Tom for reminding us of the gravity and the intense seriousness of the issues we have been discussing. We are grateful, and it seems an appropriate way to finish the day and a half that we have had together.
The panel and I will carefully consider everything that we have heard. The contributions from the table and from the public gallery have given us a great deal to think about, particularly from this morning's discussions and yesterday's, but especially more practical proposals we have heard for what needs to

change to improve the protection of children in their contact with the health services.

I would like to thank Riel Karmy-Jones for her excellent facilitation today and yesterday, and I would also like to thank Rebecca Chaloner and Bethany and Jennifer for all the work they have done in the planning and preparation for the seminar, and finally, very particularly to those of you in the public gallery, and thank you for your continued attendance at these seminars, which we very much value. So thank you for the trouble you have taken to come here and for your comments and observations. Thank you.

(1.05 pm)

(The hearing concluded)

I N D E X

KARMY-JONES (continued)

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