Monday, 16 July 2018
(10.30 am)
Welcome and opening remarks by THE CHAIR
THE CHAIR: Good morning, everyone. I am Alexis Jay and I am the chair of the Independent Inquiry into Child Sexual Abuse and sitting this week with the other panel members of the Inquiry: Ivor Frank, Professor Sir Malcolm Evans and Drusilla Sharpling.
Welcome to the sixth of the first substantive hearing of Children in Custodial Institutions investigation. Today the Inquiry will hear from some of the institutions, local authorities and further evidence from the investigations expert witness.
Ms Hill, if there are no matters to deal with prior to hearing the witnesses, I will now invite you, as counsel to the inquiry, to call the first witness.
MS HILL: Thank you, chair. There is just a couple of matters by way of housekeeping if I may. Chair, you and the core participants have been made aware of the witnesses we propose to hear from today and tomorrow. You will see that we have quite a lot of evidence to get through, so I am grateful, chair, for your indication that you are willing to sit until 4 .30 today, but no later.
As far as tomorrow is concerned, I think the CPs

have been made aware that we propose to sit at 10.00 am and conclude at 4.00 pm in order to get through the evidence. I have circulated a very broad timetable for today, chair, that I believe you and the core participants have that we will endeavour to stick to as best we can.
Mr Straw will question the first witness.
MR STRAW: I'd like to call Mr Mulready-Jones.
MR ANGUS MULREADY-JONES (affirmed)
Examination by MR STRAW
MR STRAW: Mr Mulready-Jones, could you describe your current role, please?
A. My role is as lead inspector for children in detention for Her Majesty's Inspectorate of Prisons, so I am responsible for leading on policy, I lead many of the inspections of YOIs holding children and I contribute or I lead our contribution to the multi-agency inspections of Secure Training Centres.
Q. Chair, with your permission, I'd like to adduce two witness statements produced by Mr Mulready-Jones, which are HIP000018 and 21 and then a statement by the Chief Inspector himself, Peter Clarke, which is HIP000012 and the Deputy Chief inspector Martin Lomas HIP000017.
Mr Mulready-Jones, in Peter Clarke's statement which

I have just mentioned, he describes over the first few paragraphs the responsibilities of the Chief Inspector in respect of child custody, so I don't need to ask you about the detail of that, but could you just give a brief overview, please, of the responsibilities?
A. So Her Majesty's Inspectorate of Prisons has a responsibility to inspect the treatment of prisoners, including children and the conditions and facilities that are available to them, broadly speaking. Our remit with regards to children is only in two of the three sectors that currently exist. We have no role in secure children's home inspections.
Q. Turning, first then, to the issue of safety generally, please. Could we have a look at the annual reports at 2016 to 2017 published on 18 July 2017 which is at INQ001442, if that could be pulled up on the screen, please, and within that, page 9. Could you zoom in on the bottom half of the page, please? I'd just like to read out a couple of sections of this and then ask you a question about it.
The inspector here describes the custodial estate for children and young people and noted that the outcome of the inspections had been very troubling. In early 2017 he, "felt compelled to bring to the attention of ministers my serious concerns about our findings", he

says:
"By February of this year, we had reached the conclusion that there was not a single establishment that we inspected in England and Wales in which it was safe to hold children and young people. The background to this dire situation is significant."
Then he goes on to read out a number of statistics.
A new annual report has been produced more recently than that, just on 11 July last year. Could you please describe how the situation has changed, if at all, since then?
A. The situation is better. The situation in early 2017, there was a point in time that none of the institutions were judged "reasonably good" or "good" on our healthy prison test of safety or the Ofsted test of behaviour and safety in the Secure Training Centre framework. The judgments are slightly different in that framework, so it will be none of those institutions would have been "good" or "outstanding".
Since that time, there has been some improvement in this area and we have seen several of the institutions be awarded our grade of "reasonably" -- "reasonably good". However, this has been to reflect some of the activity that's gone on in terms of behaviour management more broadly and not specifically their response to

allegations of abuse, particularly sexual abuse.
Q. So in the realm of safety, how are STCs, for example, doing?
A. STCs, there are problems across the estate. So I don't believe, as it stands today, I think the justice -- the most recent judgments are "requires improvements" and/or "inadequate", which are on the test of safety which includes child protection and behaviour management, which obviously includes what we would call in sort of common, everyday speak "safety", because that would include things like violence and restraint and that sort of thing.
There is -- what I would say is, while we have seen improvement in processing in some of these areas and we have seen demonstrable improvement in some of those outcomes, some of those trends we have seen in increasing violence, increasing use of force in these establishments has continued this year, from last year so it's a mixed picture but there has been some improvement since last year.
Q. Do you consider that there is a link between the issue of safety more broadly so violence in custody and the risk of children being subject to sexual abuse?
A. I think there is a link in the risk, yes. I think the -- how you get to there is more -- is not direct,

described earlier?
A. Okay, so over the previous few years, the children's custodial estate has transformed in a number of respects so the first respect is, as I'm sure that other witnesses have told you, the number of children held has gone down by somewhere between 60 and 70 per cent. That has led to a number of institutions closing. That -- that closure programme was -- led to children being held further away from home and the mix of children in custody has changed, as well, so the success of diversion schemes in the community both from the criminal justice system totally and within the criminal justice system from disposals that would lead to a custodial sentence to non-custodial options has led to a higher proportion of children in custody that are -- that have previously committed a violent or sexual offence in terms of proportion, although I'm not sure that's true of overall numbers, because if you go from 3,000 to 900 as the denominator, then the numerator on top also probably goes down as well.
So the children are more likely to be in prison for a serious crime. We have also had some instability of management in some institutions, particularly in the STC sector, where we have had lots of changes of provider, either from the private sector back into HMPPS or

though, I think that there is -- the reason we have healthy prison tests are around -- that we call them healthy prison tests is we believe there is something more than process that protects children, so actually how children are treated by staff, how they're cared for by staff. How staff respond to everyday requests for things like toilet roll, and so on, has an impact on how safe and how confident children are in reporting some of the bigger things that go on in those institutions like being victimised in terms of violence and victimised sexually, so -- and so the -- so I would say that when you see an institution with scores that are lower across all of the tests, you would see a more risky institution with regards sexual abuse than one that had higher scores although it's not a direct link.
Q. Mr Lomas put it, in paragraph 9 of his statement, in this way:
"We believe the everyday nature of violence and intimidation impacts on the likelihood of children to trust the institution to protect them if they report sexual abuse from other children or staff."
Would you agree with that?
A. Yes.
Q. Are you able to help the panel on the causes of the decline in safety and the mixed picture which you

between private sector providers and we have seen uncertainty, massive uncertainty, around the one institution that hasn't changed provider where that provider attempted to sell the institution then didn't sell the institution, which has caused instability there.
We have had -- up until very recently, we have had a -- not just instability of staffing at the lower levels, but all the way up right to the director responsible for this area of custody. I have been in this post for three years and I have known several directors that have been responsible for children's custody. So there has been an instability of leadership from the top right the way down to the bottom, in terms of those frontline staff who are working with children on an everyday basis, although what I would say is the instability at the bottom of the sort of band 3 prison officer grade or the private sector equivalent has a huge impact on children's feelings of safety both in terms of their perception and the reality of their safety in terms of their day-to-day experience. So there are many, many things that have happened in this way, so the last six, seven, eight years.
Q. Why has it had a huge impact, you mention the staff at the bottom and the turnover of staff at the bottom being

particularly problematic. Why is that?
A. Because if you take what we know about children and how they form their relationships and what makes children flourish, these children are not different children to children in the community, so if we talk my children or anyone else's children in this room, we would hope that they would be raised by a consistent care giver and that that would make them more resilient when they faced problems as they grew older. And if you live on a unit for a number of months with members of staff that come and go, that you don't know their names of who's unlocking you in the morning and who is locking you back up at night, you don't know who is eating lunch with you in the middle of the day, that has a huge impact in the same way that, if we changed a placement six or seven times in the community, we would say that would be a poor outcome for that child.
Q. I think in the reports, this is noted as a concern, for example, just for the purpose of the note in the Rainsbrook report which is at HMP000193 at paragraph 19, the staff turnover issue was noted to be -- to pose major challenges. Is it right that turnover has been, at least in 2016, up to 67 per cent annually?
A. Yes and those numbers, I mean, I would -- those numbers at that point were particularly high because that was at

a point of changing of providers, I think that was an inspection -- although I'd have to check for clarity, but that was an inspection that had an "inadequate" judgment attached to it, that report, or certainly a "requires improvement" judgment.
But while that was the highest staff turnover we saw, or we have seen over recent years, we have seen, similarly, high or too high turnovers at both public sector and private sector sites and not just in the STC sector.
Q. Have there also been staffing levels which are lower than they should be?
A. There have been staffing levels at times that have been too low, so -- and that impacts, again, both in STCs -- that has an impact generally in STCs, the impact has been around the sort of closure of units and the capping of places. In YOIs, the impact has been on the regime, so what has happened in the YOI sector is either the prison has been unable to deliver a regime that involves all of the activity that a child should and deserves to get and the child is locked up for longer or the response to requests and issues that go on in that establishment are not as swift or as good as they should be.
Another impact of how the prison service manages

this is it uses staff from other establishments to come into that establishment, which, again, has the same impact as what I talked about before of inconsistent responses to everyday requests. So you have a member of staff from HMP wherever who is coming to Feltham or Cookham Wood to bolster the service, so whilst you might be able to do the basics, well, there is -- sort of, the underlying care isn't improved through that sort of approach.
Q. In your report which is at INQ001453, we don't need to turn this up but it's the most recent Children in Custody report, you mentioned the simple example of staffing issues being able to have detrimental impact on something as simple as the child's ability to use the telephone.
A. Yes. To use a telephone, have a shower, specifically this is in YOIs, in STCs the design of the buildings means, and the provision of telephones means, that they would have access to those things.
Q. I will come back to that a bit later. A difficult question, but what can be done about it; the high current levels of staff turnover and the problems with staffing levels?
A. I think that there are several things that can be done about it. The first thing is to say that this isn't

a problem that can be solved tomorrow, which is -- but there are a number of things that we, in terms of our own witness statement, have suggested that might increase stability in the sector. The first is around minimum entry standards and training and experience for staff working with this age group and the second is around what the job entails. So if you have a custodial sector that is struggling, those new staff that come in straight from the entry level training course, the POELT course or the initial training course in the private sector, they're coming into a very, very difficult often chaotic environment where the person that's -- that might be mentoring them or the person that's in charge of them might be temporarily promoted. They might not have huge amounts of experience as well. The person above them may also be temporarily promoted as well, so I think the issue is around getting the recruitment right, making sure that the people that you are recruiting are able to do the job, but then also improving what their initial induction to the establishment is, to ensure that you keep them. I mean, what we have seen is some attrition from new entrants, particularly, I think, in the STC sector.
In terms of that recruitment, I think the -- that's not an overnight solution. You have to go from today

until, you know, this will be ongoing, certainly at some sites. There is something about terms and conditions, but I think some work has gone into that. What I would say is that there are now entry level salaries that are comparable to other professions, and I think, if we are paying professional salaries, we should be expecting professional qualifications.

Q. I will come back to qualifications a bit later, if I may, but first wanted to cover the issues of privatisation. We have heard serious concerns being raised about Medway and Rainsbrook when they were in G4S control. Is this a fair summary of the other two institutions which G4S continues to control: Parc, the most recent survey and inspection judged its safety as "reasonably good", whereas Oakhill STC, which is G4S's second and final current child institution, is doing poorly in terms of safety and, indeed, concerns were raised with the ministers, is that correct, by the inspector, because of how poorly it was doing?

A. Yes, we raised a -- we raised concerns at the last inspection. We have just been to Oakhill recently so not that inspection, the inspection before, regarding levels of violence and a general lack of control of the institution.

In terms of, I think was there a broader question

about privatisation?

Q. Yes, do you have a view whether private companies running custodial institutions for children makes it more difficult to care for them?

A. In terms of the evidence for inspection, there is no evidence regarding the type of provider and the outcomes we see. We see very poor outcomes in some public provision, we see poor outcomes in some private provision and, equally, we see some relatively good provision in both sectors.

We don't see -- we see some very reactive managers in some -- in some private sector institutions, we see some poor managers. What I would say is, where we find good outcomes, we often find good leadership at that same institution and that's the thing that matters, rather than the provider, and absolutely we have found the sorts of poor practice that have been national news at other institutions.

Q. A slightly different question which is about contract management of private companies. Could we turn up, please, HMP000187. This is something that was provided by HMPPS. It comes up. It's an internal analysis of Secure Training Centre contracts and can you turn, please, to the third page of that. As you can see, it was written on 21 March 2016 and four points are made at

the top there, which include these. The first one:

"There is a concern due to the self-reporting nature of the current STC contracts with a significant reliance on contracts to provide data without a robust independent assurance mechanism. Under-reporting of incidents and issues therefore cannot be successfully detected or challenged. The assessment of contracts tends to focus on processes and not necessarily the quality of the service delivered."

Then the final bullet point:

"There is a critical need for triangulating data from different sources to form a holistic overarching picture."

Do you have any recommendations as to how contracts of private contractors can be better managed?

A. I think it's probably outside of the remit of the Inspectorate to do so. What I would say is, when we inspect an institution, we look for outcomes of the people that are living there and what I have noticed, as I go around inspecting institutions of all types, is that often a lot of the things that are measured are process. So there are lots of KPIs, but around process rather than outcome, and we would do some of that triangulating on inspection to come up with those outcomes that are delivered. But in terms of

recommendations, I'm not sure I could give you any clear ones around contract management.

Q. Okay. The next issue, then, is CCTV. Could we turn up, please, INQ001480. This is the 2017 report of Medway and have a look, please, at page 10 of that. Paragraph 29 it says:

"The centre still lacks CCTV coverage in areas where young people have consistently reported feeling unsafe, such as stairwells and education block. However, inspectors were assured that CCTV coverage is shortly to be extended across the centre and included in the improvement plan."

First question, do you consider CCTV as important for safety?

A. I think it is important but I don't think it's the most important thing. I don't think that we can monitor these places safe. The focus is on staff and relationships, absolutely and that will be -- if I was going to give one message, I think that that's the issue.

The process is important and the fact that children feel unsafe in those areas is important and needs to be addressed, which is why it's referenced in that report, so it has a part to play but it's not the whole picture.

Q. So far as you're aware, does CCTV currently cover all

public areas in youth custodial institutions that you inspect or are there still gaps?

A. There will definitely be gaps across the estate, yes. I couldn't tell you how many gaps sat here now, but there will be gaps and there will also be gaps, in terms of maintenance gaps, as well across the estate, of CCTV cameras out of action at certain points.

Q. Page 25, please, at the bottom of the page, paragraph 116 says:

"Some urgent remedial training ..."

This is still the report about Medway:

"Some urgent remedial training has been rolled out across the staff group, including the safeguarding module of the NOMS training course to ensure that a minimum level of awareness is universal. This is valuable training, but it is only a day in length and cannot be regarded as enough to ensure that the workforce is sufficiently aware of the safeguarding issues. A range of appropriate further training is planned and the volume of expression of interest from the staff group is a good sign. However, the impact of this training is some distance in the future."

Are you aware of what the current position is in YOIs and STCs in terms of training; is this amount of training referred to in this paragraph given in terms of

safeguarding or is more?

A. There is safeguarding training available for staff in YOIs and STCs. I think the -- in terms of the equipping staff for the role, I think there are two things in terms of what qualifications and experience staff come into the role with and what training is provided to those staff once they get there, and I would -- again, while it is important that staff have a current and up-to-date knowledge of safeguarding, they will also need other things as well to be able to work in this sector appropriately.

Q. Focusing on ordinary staff, so residential staff that have day-to-day contact with children, do you think there should be a minimum qualification level for those staff coming into working with children?

A. I think we should start to expect qualification levels in terms of people coming into this environment in a way that you would in other similar environments holding children elsewhere, not just in the custodial sector and that may well have two impacts, not just on the children that are involved here, but on the expertise that you would then draw on, because, at the minute, we seem to have two children's workforces in the criminal justice system. We have a community workforce and a custodial workforce and there is very little sharing of expertise

and information between those two, and I think that the way they're recruited and retained is part of that issue.

Q. What about training, leaving the initial qualification to one side, do you think the mandatory training for residential ordinary staff that they receive about safeguarding at the moment is sufficient or should be improved?

A. I think that the -- that if all of them get the mandatory training, then the training is sufficient, but you would need to talk about starting points of all training, so if you had, in the same way that you would talk about the outcome is, in terms of, rather than the training programme, the outcome should be that all staff have a current and good understanding of safeguarding and how the process works. Some staff may come in with that knowledge and other staff may not come in with that knowledge, and what training each individual needs, in the same way that you wouldn't expect two children, one that's come in with GCSEs and the other with entry level 3 qualifications, you wouldn't expect the same provision to be provided for them children, you wouldn't expect the same provision to be provided for staff coming in.

Some people come in with degrees from the Prison

Service College, some staff don't and I think we need to have a more nuanced approach to this. So I think that the approach requires improvement to take account of that.

Q. Next paragraph, please, on the same page, you go on to discuss, 117, supervision in Medway:

"There is no expectation that unit staff and managers will engage in a supervisory relationship."

One sentence later:

"Supervision is an important tool to promote good quality childcare practice in other residential provision for under 18s, such as secure and open children's homes. It is difficult to see how custodial officers will be helped to continually improve their performance and maintain a child-centred focus without this, given that most staff have no childcare- or youth work-related qualifications. It is also currently unclear how poor performance by staff is dealt with."

Looking at YOIs and STCs generally, do you have similar concerns; do you think that supervision in those establishments is sufficient or it needs to be improved?

A. I think we have similar concerns across the estate. There are particular issues around supervisory relationships, so how many direct reports some staff have, particularly in the public sector where custodial

managers in some institutions have a large number of direct reports that cannot be supervised in a way that you or I would be supervised in our job roles, in terms of touching base with your manager every so often, and it simply wouldn't be possible with some of these residential managers. The reason that is, is that the supervisory officer that sits between the custodial manager and the band 3 officer has no line management responsibility.

Q. A slightly different question about staffing. In Mr Lomas' statement at paragraph 20, he indicates that, in his view, the role of residential staff should be primarily one of care. Do you agree with that?

A. Yes, I think that that underpins any model of safeguarding that the staff should know the people that they're looking after. They should have some regard for those people and there should be a relationship of trust that develops, so that if -- that prevents any type of abuse happening in the first place, but if it does, it means that children are confident that if they tell their unit officer, who they spend most of their time with, that that's what -- they have confidence that something will be done about it and, while that something is being done about it, they're protected from further harm by that very same officer.

Q. And that primary role of care, is that currently the case in YOIs or STCs or should changes be made?

A. I think there should be changes made to focus on that, but that's not to say there are not officers that see that as their role, that's not to say that there aren't managers that see that as an aspiration. I think there are structural difficulties, one of them being the high number of -- the high amount of churn we have seen recently in the workforce in these institutions and the other is the very difficult environment. It's easy for me to sit here in this room and say that prison officers and their private sector equivalents should be caring for children, but actually, if you come on to shift and you're -- and you are having to challenge some very difficult behaviour straight from the start, all week, I think you would need some support and some real guidance to explain what care means in that setting and I think that that's missing and that's where the management of those staff and that supervisory relationship comes in.

Q. Moving on to the use of force and restraint on children. The Chief Inspector of Prisons produced a report in November 2015 which is at INQ001441 -- we don't need to turn this up -- reviewing the early implementation of the MMPR, the minimising the management and physical

restraint process, which at paragraph 5.68 noted that, for children who have been victims of abuse in the past, restraint can be a highly traumatic experience.

Updating the position to now, do you consider that the MMPR process has been successful or can more be done to reduce the incidence of unnecessary restraints?

A. I think, well, yes, more can be done to reduce the incidence of unnecessary restraint, but, focusing on the system of restraint, again, in the same way, is a little bit of a red herring here. The -- it's the behaviour management that reduces the need for restraint in many -- in children's institutions, the overwhelming majority of restraints are in response to violent incidents or incidents of self-harm, and what you need to achieve in terms -- in order to minimise unnecessary restraint, is to have staff that are able and capable to defuse situations before they get to the point where restraint needs to be used and that's how you minimise the restraint.

Then you can get into a discussion about whether this technique or that technique is suitable, but, actually, the bigger and more meaningful discussion is about what happens before restraint when you're managing a dispute on a residential unit.

Q. Strip or full searching so removing the clothes of

a child and then searching him or her, we understand that there is a process whereby a form should be completed which describes the reason for the search and that the appropriate authorisation has been achieved for it. Firstly, is there evidence that those forms are always properly completed or in some cases are those not properly completed?

A. In some cases they will not be properly completed. Again, I couldn't give you a magnitude at this time.

Q. Just a couple of references. I have noted that in a recent Medway report in 2018 at paragraph 10 and also in the Rainsbrook 2016 report, which is INQ001571, at paragraph 94, there was some comments that the forms weren't being completed properly.

A second question about strip searching: we heard that it was hoped that if there were safeguarding concerns about the child -- for example, had been abused in the past -- then those would come in through the ASSETPlus assessment and would be filtered into the decision as to whether strip searching would occur in an individual case.

Do you have any comments on whether that aspiration works in practice?

A. I think that that is an aspiration that in many of these institutions is unrealistic. I think that the -- that

that information will filter into the institution, but, in their current format, those searches will be authorised on a fairly dynamic basis. So it's not -- people don't meet up in a room before the decision is made to authorise a strip search; it's often at the end of a restraint. It's often because there is an intelligence around a weapon or some other unauthorised article and that -- then the risk assessment is done and authorised on that basis.

I think if you think of an institution -- just picking one like Cookham Wood, where you've got 160 or 170 children, many of whom would have had prior experience of abuse, for that individual member of staff to know that individual child at that point, when they have got hold of them in many respects and to -- and to write that down and note that or consider that in a risk assessment I think is a difficult position to put in.

There are other searches that are authorised where you would expect that to be completed and that all to fit, but I don't -- I'm not sure if that is, as I say, a -- in the current form of these institutions, I'm not sure how you would always guarantee that that would happen.

Q. Thank you. Moving on to the question of whether there are barriers to disclosure of sexual abuse, so factors

that might discourage a child from disclosing abuse, Mr Lomas says at paragraph 12 of his statement:

"In order for children to have confidence in reporting something as significant as sexual abuse, they need to have confidence that staff will take their allegations seriously."

I would like you to help the panel, please, with just looking through the recent statistics as to whether children do have confidence in that.

Could we turn up, please, INQ001200.

The computers seem to have stopped working.

The file is not in there, okay. 1200. Can we try the number again just in case, it's INQ001200.

No, okay. We will try and resolve that and come back to that issue later.

A. If it's helpful, I have the data in front of me.

Q. You do? Excellent. That will help. In that case I will go through with you, then. This is the appendices to the Children in Custody, 2016 to 2017, report, so the most recent one. Could we have a look, please -- it's not sequentially page numbered, but could we have a look at appendix A2, so, "Survey responses from children and young people in STCs". Do you ask the question, in STCs:

"If you had a problem, who would you turn to?"

A. Yes.

Q. In 2017, overall in STCs, are these the figures: no one, 21 per cent; staff on the unit, 41 per cent; family, 43 per cent.

Just pausing there, were family the individuals who children were most likely to want to turn to if they had a problem?

A. In 2016/17, family is the most -- yes.

Q. Okay, with staff second?

A. Yes.

Q. Then you list a number of others, teachers, key worker, case worker and, at the bottom, advocates, is that right, at 9 per cent?

A. Yes.

Q. The remainder of the position about -- you ask a number of questions there, for example, "Are complaints dealt with fairly?", which is over the page, 54 per cent of respondents said yes. Over the page again:

"Have you ever felt unsafe here?"

22 per cent of respondents said yes. And then over the page, 8.10:

"If you were being bullied or picked on would you tell a member of staff?"

61 per cent.

A. Yes.

Q. Because of the time, I will just skip over to the picture in the YOIs before asking you the question, please. In YOIs, I'd like to look at the survey responses by YOI and overall, please. There, to respondents in YOIs, you ask a slightly different question. You ask:

"Can you speak to a chaplain of your faith in private, a peer mentor, a member of the IMB or an advocate?"

Just pausing there, is there a reason why that question in STCs which lists a number of different staff is asked for STCs but not in YOIs?

A. Yes, although not a particularly good one. The two surveys were designed at different times and for different settings -- at the current moment, we will have a new survey combining both settings. We will be able to compare the responses from children in STCs and children in YOIs. Also, when we became involved in STCs, their population was significantly -- I mean, it is still significantly different but less so than those held in YOIs and so we took out a lot of the detail, so while that's -- there is more detail in that question, as a whole, the survey is much shorter and simpler in STCs than it is in YOIs.

The combined survey that we're currently doing will

be somewhere in between the two.
Q. Okay, but you're reviewing and rationalising?
A. Basically, yes.
Q. Okay, so moving on:
"If you had a problem, would you have no one to turn to?"
23 per cent said yes. Then you go on:
"Do you feel complaints are sorted out fairly?"
26 per cent said yes:
"Do you feel complaints are sorted out quickly?"
Only 21 per cent said yes:
"Have you ever felt unsafe here?"
39 per cent said yes. Then over at 9.10:
"If you were victimised, would you tell a member of staff?"
28 per cent said yes:
"Do you think staff would take it seriously if you told them you had been victimised?"
Only 27 per cent said yes.
Can you help broadly in that, why is the picture in YOIs so bad?
A. The picture in YOIs is so bad for those reasons that I have told you earlier on. I mean, these are institutions where they -- there are -- well, until very recently, there has been an inconsistent staffing

survey. The system works differently in STCs. The -- you know, people get on their emergency cell bell for a number of different reasons, but, you know, often they're asking for things like toilet rolls or minor things. It's an emergency cell bell; they're not really meant to be asking for toilet rolls when they're pressing it. But, as I say, if you're living in an institution that cannot guarantee those basics of everyday life, I'm not sure you would have the confidence to do something.
If I say that you have assaulted me in a YOI, I'm putting myself at risk and someone else has to protect me. And I need to trust that they're going to protect me and they're going to be able to keep you away from me.
Q. Mr Lomas, in his witness statement at paragraph 14, indicates family or friends -- positive relationships with family or friends is a protective factor.
Over the page in your survey, you ask some questions about family and friends, 12.1:
"Are you able to use the telephone every day?", and 68 per cent of respondents said yes.
12.3:
"Do you usually have one or more visits per week with family and friends?"

picture. There has been an inconsistent regime in many of these institutions, so you don't know what is happening from day to day, and the approach to behaviour management hasn't been sophisticated enough to incentivise people to behave. So when children come out, they're coming out to fairly chaotic environments where -- I mean, I don't want -- the violence is an everyday feature. It's unusual in an YOI to not have an alarm bell going at that day or on a particular day, requiring a staff response.
Now, if you see all of that going on, the institution is meant to prevent all of that happening to you, it's meant to prevent -- it's meant to ensure that you get up at a time, that you go to school at a time, that you have your lunch at a time, that you are out of your cell consistently for this amount of time and that you don't experience violence.
Now, if you see, every day, those things happening, you're not going to trust the institution to respond very well to your problem, when you see it. If you see that the institution is responsible for stopping this stuff and can't stop this stuff, then you are going to have a lack of faith when you raise the issue yourself.
The other thing to say is you will also notice there is a question about cell bell response times in the YOI

And only 34 per cent of respondents in YOIs said yes.
12.4:
"Is it easy, or very easy, for your family and friends to visit you here?"
And, again, only 32 per cent of children said yes.
In terms of telephones, are telephones always in private or in some YOIs are they in positions where they -- the child may be overheard when talking to their family and friends?
A. Yes, sorry, to answer the question, they're not always in private in YOIs and they are sometimes in places that they could be overheard. It just depends on how close people are standing to you whilst you're on the telephone.
Q. In the Feltham report in 2017, INQ001205, you -- I think the inspector notes that the telephones are held in corridors; is that right? So there may be children walking past or members of staff as they're talking to their family. And is it also correct that telephone calls with family are not necessarily confidential, so a member of staff might be listening --
A. Yes.
Q. -- to that? And visits also, is it right family visits tend to be in a big hall so not confidential?

A. Mm-hmm.
Q. And may -- or if a child wants to write a letter to their family, again, it may be read by a member of staff?
A. Just to put some context on that figure of 32 per cent family visits, or approximately 32 per cent find it easy, you have to put this into context. Many of these children have come in with prior care experience, and so there will be very good reasons why their family find it very difficult to visit them while they're in custody and, if you look at the annex, you will find a looked-after children comparator and you will see a real stark difference between those questions on family between those people who have a prior care experience and those people that were, for want of a better word, living at home before they came into custody.
Q. And Mr Lomas in his statement makes a recommendation that children should be held closer to the communities in which they live to facilitate those relationships?
A. Yes.
Q. And a similar one, custodial institutions holding children should be smaller to facilitate positive relationships between staff and children.
A. Yes.

Q. What do you think -- do you support that?
A. Yes. I think the two things are linked, so you hold -- well, we hold 900 children in custody, give or take, and we did a thematic inspection on the impact of distance from home and we found that you received -- broadly speaking, one view is that for every 25 miles you were held further from home, and that was visits by both family members and professionals, so in terms of that external relationship and your ability to maintain it and your ability to have contact if you did want to make a complaint or tell someone that something had happened to you, the distance absolutely matters and if you simply do the -- the maths on how you construct an estate with 900 children in it, you would have to have those -- to enable them -- people to be held anywhere near where they're coming from, you would need to have a greater number of smaller institutions.
The smaller institutions is more about smaller living units and personal relationships on those units, so in theory, you could have a very large institution that was broken up into lots of small living units, that sort of mimics a smaller unit, but that's a point that we're driving at there in terms of the size. It's a size from the perspective of the child, so if they are living on a smaller part of an establishment, I suppose,

from their perspective, that makes little difference to them, whether it's a -- the establishment is much larger.
Q. Whistleblowing, Mr Lomas says at paragraph 15 there is evidence to suggest that staff in custodial institutions holding children rarely blow the whistle on poor practice and abuse carried out by colleagues.
Is that your understanding of the position?
A. Yes, I think we do see examples where staff do blow the whistle on poor practice, but we -- they are -- they're not as many as you would like. Again, I don't think this is a problem limited to the custodial estate. I think we have seen similar in -- across all professions, I think people are reluctant -- in the same way as we ask that question, "Would you tell a member of staff?" or "Would you think your complaint would be taken seriously?", I would suggest that many people working for a range of different settings would say, "I'm not quite sure I trust that whistleblowing hotline or the ability of this institution to protect me if I put my head above the parapet".
Q. Okay, I'm sorry, we're rather rushing through all the issues because we have very limited time. So I will move on to the response. In the Medway -- in one of the Medway reports, which is, let me just get the year, the

2016 report, there were concerns -- and the reference is INQ001479, but no need to turn it up -- and concerns were raised that child protection matters were not managed effectively and young people were not sufficiently safeguarded and it drew attention to a number of specific concerns about the responses to child protection referrals.
Is that only Medway or are there concerns in some other places?
A. There are concerns in some other places at different points in time, so that's a relatively dated assessment of Medway, as we stand today. I think there have been two subsequent inspections of Medway and I think their safeguarding has been assessed as marginally improved from that report.
However, those sorts -- I think that report says that there were five delayed referrals and one of which the local authority didn't have a record of.
The one about the local authority not having a report of is unusual. We rarely find that. We do find delays, so the general problem with referrals to local authorities is the timeliness, making sure all of the information goes with the referral and, to be frank, then chasing up the local authority to make sure that the local authority is investigating in a timely

fashion. But that's not an unusual -- those sort of five that were out of time, and all there were delays with, it's not unusual for us to find that in other institutions.

Q. Moving on to the inspector's powers, in the 2018 annual report, which is HIP000022 at page 63, it records, so far as safety is concerned, 34 per cent of previous recommendations were achieved, 15 per cent partially achieved but more than half, 51 per cent, were not achieved.

Has a similar picture been in place over the last few years?

A. I think there has been a decline in the system. Those figures are a response to all inspections across all sectors. The -- there has been a decline in the number of recommendations that have been achieved from the previous inspection in general, so it's been getting worse.

Q. Okay. And at INQ001580 there was a press release from Peter Clarke, the Chief Inspector of Prisons, dated 16 February 2018, in which he was discussing concerns about Liverpool Prison, an adult prison, and the Justice Select Committee's response to it, but in that context, he made this comment, that he would welcome the Select Committee's recommendation that independent

scrutiny needs to be injected into monitoring the implementation of inspection reports, and he said:

"It is crucial that progress in implementing HMP recommendations is transparent and independently verifiable. The abject failure of too many prisons to take inspection reports seriously must stop."

Do you support a sort of mechanism of that form where there is some form of independent scrutiny of recommendations?

A. Yes, absolutely. We regularly find that the institution's own assessment of where they are and how many recommendations they have achieved is optimistic and of a different order to what we -- they make the assessment of when we follow up those recommendations. So it would make sense that if we are making these recommendations, then, in those establishments that are struggling, that we -- there is some mechanism where we would be able to go and check that those recommendations are being implemented appropriately, both in terms of making sure that the establishment understands the purpose of that recommendation but also in some -- you know, as well as sort of from a sort of audity perspective, as well.

Q. The inspection regime, we have a number of documents on the system, including the HMIP inspection framework from

February 2016. There is a guide for inspectors as well from January 2018, a safeguarding policy. The references are HIP00008, then 9, 10 and 11. Does the inspection regime apply equally to STCs and YOIs?

A. The inspection regime?

Q. Yes.

A. The inspection regime is different in all three sectors, so the STC inspection regime happens annually, as does the YOI inspection, but the frameworks are different, so the YOI inspection framework has four tests: safety; respect; purposeful activity; and resettlement. The STC inspection regime has more tests which include safety, behaviour management, care, healthcare, resettlement achievement, leadership and management and overall effectiveness, so there are significant differences in the structure of the report. In reality, we looked at very, very similar things, particularly in regard to safety, but the make-up of teams is different. While we have Ofsted, CQC and ourselves on both inspections, we lead in YOIs, Ofsted lead in STCs, Ofsted have the bulk of the inspection team in STCs, whereas the reverse is true in YOIs, and the -- as I say, we don't -- some of those tests you will notice are completely absent from YOIs while they're involved in the other one, and we certainly don't have that overarching judgment in the

YOI sector.

So in regards to frequency, yes, it's the same, but in terms of what that looks like on the ground, there are real differences.

Q. Mr Lomas, at paragraph 26, said:

"There should be one inspection regime for the sector, YOIs, STCs and SCHs, that continues to give significant weight to safeguarding and child protection."

Would you support that?

A. Yes, I don't think there is any good reason why we inspect these three sectors differently.

Q. The Chief Inspector has also said in public that, in fact, in his most recent annual report that the inspection regime ought to be -- have a statutory footing. Do you support that and, if so, why is that important?

A. Yes, I do support that. I think there was a Prisons and Courts Bill that got lost in the mists of time that would have assisted HMIP and put some of our powers on a more formal footing. Some of that has happened already in terms of the urgent notification process and there is -- there are developments happening in terms of following up from inspections, as well.

But putting the organisation and inspection on

a statutory footing, while our actions are independent as we are now, in reality the organisation is an arm's length body of the Ministry of Justice and we have -- and the organisation itself still is not referred to in any sort of legislation. We are just a Chief Inspector.

Q. Should there be a greater investigation during the HMIP's inspections of safeguarding issues? I have two suggestions here, but please do tell me if these are already part of your inspections.

So, for example, analysing the proportion of staff which have received mandatory safeguarding training or to test staff's understanding of key areas in respect of safeguarding. Do you think what's asked at the moment or what is inspected at the moment is sufficient or more can be done?

A. We ask as part of inspection of our inspection methodology for training figures for a large range of things, including safeguarding training and inspectors, I would expect them to be, as they were going round -- particularly residential staff -- to be asking how they would make referrals in terms of safeguarding.

A point, though, about safeguarding and our framework, there is a section called "Safeguarding and child protection", but there are also sections around suicide and self-harm prevention, violence reduction and

the survey findings alone. We then triangulate that with evidence we have collected during inspection.

What the survey does do is give an accurate picture of the perceptions of a very large number of children that are detained at a point in time, so we have about a return rate about 84, 85 per cent, which is very, very high and we have been doing this for a number of years, so you can monitor sort of trends and things getting better or worse, but the survey is absolutely not designed to get an accurate picture of child sexual abuse in custody over a period of time. It can only do what it's designed to do, which is to take the perceptions of the children at the time that the survey is conducted.

Q. Howe & Co who represent a number of core participants have put forward a question or suggestion of statutory agency, perhaps similar so the US Bureau of Justice statistics whose role is to collect, monitor and perhaps audit allegations of sexual abuse. So to carry out a wider and more detailed survey. Do you have any comments on that?

A. I think that there is nothing wrong with having a statutory agency with responsibility for making sure that these statistics are accurate and that they are all reported. I see the recommendations, such as

so on, which are obviously also safeguarding too.

Q. Surveys. In the witness statement by Peter Clarke, May 2016, he noted that since 1 January 2002 until the date of his witness statement, so it's a slightly different period to what the inquiry has been looking at, HMIP had records of 221 reports of alleged sexual abuse against a child in a custodial institution. Now, have you heard that the inquiry has asked all relevant bodies to produce information about allegations that they had received and in the period between 1 January 2009 and 31 December 2017, a slightly different period, there were 1,070 allegations as a whole.

Do you have any comment on that? Is the Inspectorate supposed to be there to get a complete picture of abuse or is it just a snapshot at the time of the surveys?

A. We are there to inspect, as I said before, the treatment of prisoners and the conditions in which they were held. Now, that is much wider than the prevention of abuse, so the survey itself is designed as a tool to inform inspection. So what the survey does is gives inspectors looking at that area -- whether it be victimisation, in this case -- whether it looks like there is a particular issue at this institution. What we never do is rely on

HMI Prisons to collect the data. I think, if there was a duty, that would have to come with resource.

A point about the methodology in the United States is that their survey methodology is a sample survey, the it's not -- they don't survey, as we do, every single child. They survey roughly about 15 per cent of the children and they don't do it as frequently as we do. They rely, also, on report data from the institution and from the institutions in terms of allegations of abuse which is probably a very similar route to some of those other route -- allegations that make up your total number that you've described.

I think it makes sense for them to be together in one place, but I think I would be cautious of saying, "This seems to look good over here and so we would implement it there". I think there are things that probably are better, but there are some things that maybe are not as robust as what is happening here at this minute in time.

Q. I think you have seen the Howe & Co proposals for reform. Another question they have asked is whether you support a child safeguarding authority. Do you have any comments on that or any of the other proposals for reform that Howe & Co have put forward?

A. I think the creation of a child custodial safeguarding

authority, while I can see the sentiment behind that, I think there are risks involved, what the Inspectorate would like to see is a competent safeguarding authority that applied the same thresholds to children in custody as children in the community and ensure that they were protected.

I think in the current system we have local authorities with that duty and some of them, obviously, are -- some of them operate more effectively than others and that, I suppose, is a danger, but one of the risks of having a child custodial safeguarding authority is that that becomes separate from children in other settings in a way that, when I talk about workforce, it's perhaps not as -- you know, it has risks as well as benefits. So you could -- you know, you could look at that one organisation and say, "Well, we will make sure that this operates well", but actually the risk is it becomes a slightly siloed service from other safeguarding agencies.

And the other thing that I think, again, to go back to my original point, which is around that I'm not sure that process and structure is the whole story here about, you know, changing this structure or that structure in terms of external oversight. I think that there is something about the fundamentals of how the

day-to-day stuff operates in these institutions that safeguard children.

In terms of one other recommendation that is made around a recommendation that we have previously made around Feltham, obviously what we would like to see is that all of our recommendations are implemented by HMPPS. I don't know whether you wanted me to comment on any of the other things in this document?

Q. I am very tight for time, so I'd better on move on, but thank you. I just have two final questions, then, two final issues. The first one is about regulation, oversight and governance. I think in Mr Lomas' statement he notes at paragraph 16 that external regulation, oversight and governance arrangements are complex and lead to institutions being held to account by several external agencies for different aspects of their work.

At 25, he recommends they should be rationalised. Do you support those concerns?

A. Yes, I think what we find is managers doing several things for several different masters, ourselves and the inspection regime being one of them, and I think one of the dangers of recommending solutions is that it's always easy to recommend another process for managers to implement and I think that what we have in some of these

institutions is an illusion of oversight because lots of people are looking at something quite briefly, so there are links of oversight to a local authority LADO who may or may not have experience specifically of what the issues are in custody. There are obviously some oversight arrangements through local partnerships or Safeguarding Boards, but, actually, they are stretched, and their ability to dedicate resource to this. Then we have ourselves who are coming in once a year. And then you have the management line, which, while it has been rationalised some way in terms of the children's -- children in custody sector -- in terms of children in custody we still have three agencies at the centre that have some oversight of this space in terms of the management, some policy input from the YJB and some policy -- some oversight from the YJB and the policy team in NOMS.

So, yes, I think that that could be rationalised and, if it was, or at least some of those processes were aligned, managers could ensure or could focus more of their time on improving outcomes in their institutions rather than oversight and governance.

Q. The last issue is just going back to the inquiry's prevalence analysis. In 2016, the inquiry's prevalence analysis found 32 allegations of sexual abuse in Medway.

As I understand it, in the 2016 survey of Medway, which is INQ001479_001, it was noted that at the time of the survey there were 36 people in Medway -- 36 children in Medway and 33 questionnaires were responded to. None of them said that they had been sexually abused on the survey and, similarly, the next snapshot, 28 February 2017, which is the next survey, the population of Medway was 29 children and, again, none of them said that they had been sexually abused.

Can you help us understand what's happening there as to why it may be that the -- there was a zero per cent response rate to the snapshot survey that you took but a number of allegations appear to have been made elsewhere?

A. I think that people respond differently to different methods of reporting child sexual abuse. I think that that -- and actually you need several different safeguards operating at the same time, so I imagine that what you have got there is people have reported to the institution or staff have reported separately in terms or there may possibly be historical allegations that involve people that have left the institution. I don't know what the nature of those allegations are. I would suggest that some of that is a churn of the population but in reality there will be -- there's no perfect

methodology in making sure that everyone reports all of the time every time they're asked.

Q. Thank you. Chair, with your permission, I'll just adduce formally a few other documents that I haven't mentioned yet. One of those is INQ001457, a report about Rainsbrook and then INQ001569, another such report and, finally, chair, just to draw your attention to two of the witness statements, which describe the number of different establishments to which HMIP had received allegations of sexual abuse from and then the statement by Mr Mulready-Jones dated February 2018, he actually gives details of a number of the allegations that have been made, so quotes there, quotes from the children themselves who have left comments on the surveys.

Does the panel have any questions?

Questions by THE PANEL

THE CHAIR: Thank you, I have one, Mr Mulready-Jones.

You have referred quite frequently to the relationship between the quality of leadership and better outcomes, so do you think that the quality of leadership across the estate is good enough to address the many and complex issues that we have been hearing about?

A. I think we would have to say no because we have assessed the leadership and management to be not good enough in

some of the institutions, with -- in the STC estate and demonstrably it's not good enough yet to deal with some of the issues that are in the YOI estate. There has been a lot of change over the recent time and have been some improvements, which is why I've given a sort of mealy-mouthed outcome, but to answer the question directly, I don't think currently we could say yes to that question.

THE CHAIR: Thank you. Ms Sharpling?

MS SHARPLING: Thank you, Mr Mulready-Jones. Just a question of clarification for me, I'm not sure whether you said it or not, that's why I am asking. Can you tell me the underlying reasons why the framework for YOIs are different from STCs?

A. They are designed by two different organisations, so while the STC framework is a joint framework with ourselves and the CQC and Ofsted, the lead inspectorate is Ofsted and so their policy team draft the framework and they commend and so on. It's not -- and also it's a hangover from a system that was larger in parts and so it made a lot more sense when there were more children in custody. It was hidden that we had sort of these different approaches in different sectors, but actually, when you get down to it now and you've only got about 600 in YOIs and another 120, 130, 140 in STCs, it does

seem odd that you would inspect those outcomes there in different ways and, again, a third way different in secure children's homes. So I think -- and it hides some comparability of outcomes across sectors.

MS SHARPLING: Which brings me on to my next question: is it possible to fix that?

A. The legislation appoints the inspectorates but it is possible, it would be possible to fix it, yes, it's not beyond -- with inspectorates drafting new legislation -- new frameworks that changed the current frameworks and I think given the reform in the sector, I think that that will be necessary when we have a fourth model of custody, but at the minute, I think the frameworks -- the inspection regime reflects a rather fragmented sector rather than a sort of taking a more strategic approach across all three types of custody.

MS SHARPLING: I see, thank you.

THE CHAIR: Sir Malcolm?

PROFESSOR SIR MALCOLM EVANS: Thank you, just one very small question: I couldn't help but notice that when we were looking at paragraph 117 of the 2017 inspection report on Medway a little while back, it mentioned that one of the difficulties was that whilst minutes were saying that individual staff would be spoken to or receive letters about their conduct, "as no staff files are

maintained, it is not possible to see whether there is any follow through here".

A. That was -- without having the report to my -- to hand, I think that was a particular problem with Medway at that inspection at that time. There was an issue about records across the site, not just records of the staff and what's happened with the staff, but records of the children and what's happened with the children in terms of their ongoing care.

PROFESSOR SIR MALCOLM EVANS: So that would be specific to Medway at that time --

A. At that time.

PROFESSOR SIR MALCOLM EVANS: -- rather than generic practice?

A. Yes.

THE CHAIR: Thank you very much. We have no further --

MR STEIN: Chair, sorry to interrupt and I don't want to delay progress of the day. We note that Mr Mulready-Jones has read the Howe & Co recommendations and proposals. He hasn't, I don't think, had the time today to go through those and provide his own opinion.

What we would ask, if he's prepared to, and as long as counsel to the inquiry has no objection, would be if he could provide an answer to those proposals in correspondence?

THE CHAIR: Are you willing to do this?
A. Yes.
MR STEIN: We're very grateful.
MR STRAW: Mr Mulready-Jones, would you be willing to produce something in writing in response to those questions?
A. Yes.
MR STRAW: Perhaps we can deal with it that way.
MR STEIN: Thank you.
THE CHAIR: Thank you very much. We will now take a break and return at 5 past noon.
(11.48 am)
(A short break)
(12.05 pm)
MR ALAN WOOD (recalled)
Examination by MS HILL
MS HILL: Thank you, chair.
Mr Wood, you're already under oath. Thank you very much for returning to give some further evidence. Just to orientate, you, Mr Wood, and the rest of the participants in the proceedings, I had hoped to ask you some very brief questions about some of the generic themes you had elicited from some the case studies material, but it may be that we should just press on to deal with the Feltham matters.

But just by way of broad introduction, is this right: that you were instructed by the inquiry to review a series of allegations of sexual abuse that were made at six institutions?
A. That's right.
Q. And I think the total number you were asked to review was around 70 --
A. That's right, yes.
Q. -- spread across different institutions, and what you're hoping to give evidence about today in particular are the themes that emerge from your analysis of both Feltham and Werrington?
A. That's right.
Q. Just to orientate the panel very briefly, and I don't want to spend very long on this at all, but could I ask you just to pull up your generic topics that you identified? It's INQ001210_025, I hope. Under the heading "8.0" at the end of your report on the institutional responses, I think you pull together just a series of broad themes that the panel might have regard to and I will just literally take you through the headings. As I say, I won't spend long on it today.
Can we scroll down then, please, through 8.1.1, your heading was this: that children were very isolated in custody and that was something that came through to you

in the material that you saw?
A. That's right, yes.
Q. Over the page, 8.1.2, one theme was an apparent perception by members of staff about the young people and that seemed to frame how they responded to the allegations?
A. That's right.
Q. 8.1.3, you've made observations about how well understood the previous trauma and abuse of the children was by the staff?
A. That's right.
Q. 8.1.4, you raised questions about how well staff were trained and supported in dealing with those issues?
A. That's correct.
Q. 8.1.5, again, a question about the role of the child having had a previous experience of authority and what that meant in terms of engaging with the complaint and investigative processes?
A. That's right.
Q. 8.1.6 was a broad theme about perhaps process rather than content?
A. That's right.
Q. 8.1.7 was a sense that some of the staff seemed to regard the children as "other" and that that perhaps formed their response to the children's allegations?

A. That's right, yes.
Q. And then, finally, a broad theme where there seemed to be a disparity in the support given to a staff member against whom an allegation was made compared to the child?
A. That's right.
Q. All right. Just so the panel can understand your broad conclusions -- and we will return, as I say, to this on Wednesday -- the following page, please, 8.1.9, you had made the point that because the children in custody are so vulnerable -- under B on this page -- you had said that the highest levels of safeguarding practice should be expected of the members of staff working in these institutions and appropriate and clear responses should be expected. But under C, your broad conclusion was that that high level of safeguarding practice had not been routinely experienced by the children across all six institutions. Is that right?
A. That's correct, yes.
Q. I think you had said that if one scrolls further down to the very end of your conclusions at M, that when looking at the key elements of the Working Together guidance that we looked at last week, you broadly said that they were all consistently absent from within the records you looked at?

A. That's right.
Q. All right, thank you. Can I try and drill down a little bit now, please, then, to some of the institutional issues that arose around the Feltham analysis that you did and can I begin, please, by orientating the panel by bringing up, please, INQ001228_002, which, Mr Wood, is just the letter of instruction you were sent in relation to Feltham, and perhaps just scroll in on that list of incidents underneath the heading "A", because that shows the panel the number of incidents and the broad date of the incidents that you were invited to look at.
A. That's right, yes.
Q. So the panel can see here that you were asked to look at 15 different allegations from Feltham. They range from October 2008 and I think you were asked, ultimately, to not look at that one because it's before our 2009 start date but you then focused on a series of allegations from September 2009 through to September 2015.
A. That's correct.
Q. Just putting that document to one side, and I won't bring these documents up, but just to give the panel a broad flavour of it, the underlying material that you were asked to look at -- the panel won't see this in your report, but I am just, hopefully, trying to give

a bit of detail here -- is that, for example, the allegation from 9 September 2009 was an allegation by a young person, a 17-year old who submitted a complaint in which this was written: he had been searched by a female prison officer:
"She sexually assaulted me by squeezing my penis a couple of times. I have several witnesses who saw the assault."
We don't need to bring that up but that's HOU000003 internal page 29. And several of the other incidents that you were asked to look at had arisen because a child had disclosed the allegation in one of the survey responses?
A. That's right.
Q. Some of the other allegations, just by way of example, that you were asked to look at involved one suggestion, I think this is 19 March 2012. An incident that you were asked to look at involved an officer coming into the cell to hand out lunch. The child was wearing boxer shorts. The officer, it was said, had grabbed the child by the genitals. That's the sort of thing you were looking at?
A. That's right, yes.
Q. And then just one, I think, perhaps final example. There was one example of a suggestion that a mental

health worker had sexually assaulted a child. Is that right?
A. That's correct, yes.
Q. I think that was the 28 November 2012 incident and that's HOU000003.
Turning then, if I may, to the themes that you elicited, can I look up, please, your second and third report. It's INQ001210 and it's internal page 8. You dealt with your views on Feltham under three headings. Firstly, you applied the general principles of good practice to Feltham. Then you dealt with some more points of detail around allegations against members of staff. In fact, forgive me, it's two headings in relation to Feltham.
Is this right, Mr Wood: that as far as the initial recording of an allegation is concerned and the initial response, we can perhaps scroll in on 3.1.1 on this page, you felt there was a wide variation in terms of the approach and standard in terms of the recordings. And I think the two themes you brought out later around this were that the record seemed to reflect a lack of understanding about the complication caused by the child being in custody, about them being scared to report. Just tell us a little bit more about that, would you?
A. That's right, yes. I think one of the major themes to

me was the fact that -- mentioned last time, some of the child's responses to custody in terms of externalising behaviours may elicit a response from members of staff in terms of trying to restrain them, so these are -- there is a gap there in terms of understanding the connection between those two things: previous experiences; and the current behaviour.
In terms of the form actually to record any allegations against staff, Feltham did stand out in lots of ways in terms of the inconsistent approach, so we have mentioned before, I think, that, actually, a large range of forms are available to use and routes in to making an allegation against a member of staff. There was inconsistency in terms of the method, inconsistency in terms of the written response. One of the themes which did stand out was that there was consistency in terms of records in terms of members of staff, so one of the concerns I had was that there were clear pathways in terms of -- from an HR perspective, in terms of members of staff, those weren't replicated from a child or young person's experience.
There seems to me a lack of impetus to examine the whole picture, linked to the withdrawal or denial of allegations being made, as well. And there was some examples of that.

Now, I think using different methods to collate information, written by different people at different times, the tracking of those things in terms of being able to learn or to improve from those examples was absent, as well, so it was quite hard actually to track what had actually happened across the range of documents.

Q. So I think you're suggesting that the documentation suggested a better insight into the impact and allegation on the staff member than the child. Is that right?

A. That's right, yes.

Q. And that there was a perhaps inconsistent approach to the support given to the child or, indeed, no apparent support from the documentation being given to the child. Is that right?

A. That's right. I think one of the things for me, as I mentioned several times in several reports I've done, that based on information I've actually seen, that's the picture. That information may be recorded elsewhere, but there was no cross-referencing to those other records which may exist from Children's Service departments from the police records, so it's very hard to see how those things actually joined up.

I could only comment on the records I have seen, so

I did mention several points. It may be elsewhere, but it's not actually explicit.

Q. Just to be clear, that is a point that's been raised in several of the institutional responses, that there may be evidence of support elsewhere. I think what you're saying is that on the core documents you were sent, on the child protection logs and things of that nature, it wasn't obvious what that support was?

A. That's right. I think, from my perspective, it would have been really helpful if a log of other potential evidence sources which are linked in terms of the major records are examined, so it's about multi-agency approaches, as well. So no one agency is responsible in its entirety for safeguarding children; all agencies are responsible. I think it is hard, though, when agencies don't actually tie in to other records, so this may be available elsewhere. It would be quite helpful to see written down, but it wasn't written down anywhere.

Q. Would that sort of joined-up approach be consistent with the Working Together approach?

A. It is completely consistent with this. I think the additional complexities of custody add a different aspect to that as well. However, all agencies are responsible for safeguarding children and young people, so it needs to be reflected across all agencies.

Q. I think another broad issue that you brought out was that there was, on occasion, a need for the child to report the allegation to more than one person to sort of repeat it and I think you felt that this was a rather difficult process. Can I ask you, please, to bring up your fifth report and, in particular, what you say about this at 1.15 and 16, so it's INQ001764 and it's internal page 4.

If you scroll in, please, on 1.15 and 16. You seem to be concerned across several of the institutions, but including Feltham, about the number of members of staff who became aware of allegations and this overexposure, you call it of the allegations. Is that something you can comment a little bit further on, please?

A. I think -- I think elsewhere in the report, and other reports, I mention the fact that just by the very nature of a custodial institution, it is actually quite hard to keep things completely confidential due to the fact of handovers of staff, risk assessments are being completed all the time on children and young people, so I think, in terms of when a child discloses sexual abuse, it is hard to keep that contained. The risks around that are that members of staff who may or may not be involved may become aware of those allegations. Other children and young people may become aware because the child may talk

to other children and young people around those confidential issues, as well, so it is very difficult to -- to actually to work through that.

I think in terms of an absence of a record of that, it would be helpful, I think, for agencies to record the difficulties they may have in keeping things confidential, and then to put in some management around that. But overall, it is actually quite hard to do that.

There were some examples in terms of institutions, talking about Feltham in particular, where children and young people were concerned that other members of staff may become aware of allegations, as well.

Q. Perhaps I can take you to an area where you deal with that in your first consideration of these issues, please, it's INQ001210_010 and scroll in, please, on 3.1.16 where I think you had raised a particular observation about a child being concerned that their complaint had not been kept confidential but seemed to be known about by the partner of the member of staff who was then treating the child differently. Is that a summary of one example?

A. That's correct, yes. I think there, again, the added complication is that the member of staff who those allegations were made against may well have spoken to

his or her partner about the allegation. Again, I think it would have been helpful to see a record from the child protection logs or some sort of record written down about this issue and say what they were going to do in terms of trying to deal with that risk factor. Certainly from the records I saw, the young person's perspective was that they were being treated in a different way, and the allegation had actually been made.

Q. Thank you. You have already highlighted, I think, if you go to the top of that page, please, a theme of the disparity in the apparent understanding of the impact on staff compared to the impact on children. Is there anything more that you would like to say about that, how that reflected itself in the Feltham records?

A. I think for me the -- one of the core issues for me is in terms of whose record it actually is. I think from a member of staff point of view, it is important obviously to record allegations or concerns or complaints and to log those and to follow a correct process associated with the contract they're actually having to work to.

One of the concerns I suppose I had really was -- it's quite clear, you can see the pathways whereby members of staff were invited to meetings. It's all

written down in a clear way. The results of those meetings are very clearly written down. You could easily pick out what the processes were, what the issues were, what the next steps were and that wasn't always so obvious when the child actually made an issue, so there is two different ways of thinking about it.

Now, it may be -- and I think agencies, I have already said in another response to the report, that those records, in terms of the response in terms of support for the child, may be lodged somewhere else, that may be the case, but there was no cross-referencing to the records I saw, so that's one issue I think in terms of evidence based work.

The issue about restraints --

Q. Let's come to that, if we scroll in, please, on 3.1.13. I think what you had mentioned here -- sorry, it's 12 and 13, forgive me -- is that there was a concern here about the way in which a restraint issue had been dealt with. Tell us what your findings were there.

A. I think for me, I mentioned several points, I suppose, that a child's pre-existing experience of trauma or abuse may configure their internal working view of the world, so they may be expecting conflict, aggression and I understand that workers are trained specifically to restrain in certain ways to cause the least amount of

harm and with the most amount of care.

I think, however -- I think in terms of how a child can actually perceive that loss of power, loss of control, it's quite clear that there's a number of allegations across the entire range I've looked at whereby restraint is a starting point, so children would perceive that restraint in a certain way. It's also aligned to searches, as well, so if children have made comments around that, as well. And the view was, this is a thorough search, this is a complete -- completely within the rules of restraint. However, the child's experience of that wasn't really recognised or picked out from that.

Now, I do understand working in an environment whereby high levels of conflict and stress are around all the time. However, that child's individual experience of that episode should be reflected, I think, in terms of the records.

Q. I think we have seen in the response by the Ministry of Justice and indeed some of the witness evidence that we will hear today that the allegations that you looked at, as we have seen, ended in 2015 but there is, now, a different process in place --

A. There is, yes.

Q. -- as far as restraint is concerned?

A. Yes.

Q. And our understanding is that there will be some debrief of the child after restraint?

A. Yes, I was very pleased to see that.

Q. What sort of thing would you hope to see that that debrief includes, Mr Wood?

A. I think in terms of -- from a behavioural response, I suppose, in terms of what was leading up to the restraint, why the staff actually identify the need to restrain or put hands on a child, enabling the child to understand what the rules were and why restraint was important under some limited circumstances.

I think for me it's aligned also to there would be a large amount of information which would be known about the child if they've got history of involvement prior to coming into custody. So all information about their past lives, experiences, their past trauma, their past child protection status, past involvement with social care or other agencies, all that should be known, so it may not come as a surprise to staff, then, if children respond in certain ways.

So actually, it's about the staff and the agency taking responsibility to understand the child as much as possible what triggers may emerge from their past experiences and also enabling the child to understand

what the rules are and how the rules are different within custody to outside of custody and what the consequences of some of their behaviour might be.

So I think a debrief is in two elements. It's the child's understanding and the member of staff's understanding. I did see the response in terms of -- from the recent attempts to improve practice in Feltham in terms of creating a log to make sure that if certain members of staff are more prone to restraining children and others weren't that could be now identified, which is very helpful, I think, in terms of understanding the staff issue as well as the young person's issue, because my experience would say that some members of staff are more skilled and more able to deescalate prior to restraint, others members of staff may move to restraint in a quicker way, so you can understand that from a debriefing as well.

Q. Just following on from that, one of the points that you have made in your report, I think at 3.1.13, was that where there was a concern that the restraint of a child had not followed expected training you were suggesting that there wasn't evidence of any follow-up with the member of staff concerned?

A. That's right.

Q. But is it your understanding that that would now occur

as part of some formal debrief?

A. What I've recently read in terms of the papers presented to me, I think the response now seems very robust now. It's quite a recent change and I think also for me it would be about understanding compliance, not only in terms of the correct forms being filled out, but understanding the child's experience of that, as well. So inspection could bring that out.

Q. Just a final question on this topic, please, to what extent would it be your expectation that that pool of knowledge about a child would be available to the staff member who has to make that decision in the moment about whether to restrain that child?

A. I would think that, I mean, the essence of a care planning process would be that key people would have to know what the presenting issues were for the child. I think that could be done in a way whereby the child doesn't feel their entire past history is exposed to a series of adults or members of staff whom they may have very limited contact with. However, I think there are key themes which could be drawn out from that, so my view would be that the pre-existing knowledge which agencies have about children in terms of experiences should be used in a child centred way, in an appropriate way, but it's essential, otherwise decisions can be

made, reactions can be interpreted in a certain way which may actually escalate the issue, the conflict issue.

And I think understanding children's point of view in terms of what relationships adults mean to them, past experiences would be useful. I think from a confidentiality point of view, that would be done in a careful way because you wouldn't want to expose the entire history of a child across the entire range of adults.

But with a key worker approach, they could hold information. The members of staff can go to that key worker and say, "Actually, I saw this today. Does this make sense in terms of the past experiences?", and a discussion could happen then.

I think in terms of the resource implication, and it's the care and control relationship which we spoke about last time, if you think about safeguarding is at the heart of all activity with children and young people, then workers have got a responsibility to make sure their actions are understood and interpreted by a child within that perspective.

Q. So I think, is this fair, that what you're saying is that, albeit fully recognising that restraint may be necessary on occasion?

A. Yes.

Q. That in deciding whether to restrain a child, the fact, if so exists, that that child has been already physically or sexually abused should be part of that decision-making framework?

A. I think -- I think, you know, sitting here, it's easy to say that in terms of a --

Q. I appreciate that.

A. -- detached view, I think, in terms of the harsh fact of having to deal with the child's escalating behaviour in front of you as an adult, and I've certainly been in situations whereby that's happening. I think the skill is understanding what's behind that behaviour and also enabling the child to feel that is another option. It does take some skill to do that and some support and some supervision and some elements around that to do that, but I think in terms of, if you don't want a child to have a repeated experience of trauma and abuse, which then adds to their sense of isolation and no control and no power, then I would say that understanding where the child's perception comes from is important. In practical ways, it's difficult to do that. I think staff would have to be trained to understand what may be lying behind some of the behaviours.

Q. Or, indeed, even if the behaviour is entirely unrelated

to past abuse --
A. Yes.
Q. -- the fact of restraint potentially retraumatising a child. Is that right?
A. My experience of seeing restraints happen, being involved in some restraints as a member of staff is that it can be a very traumatising experience for the child. My approach would be to talk to the child throughout the entire restraint, remain some contact. I think once the emotions and the heightened emotions of restraint are happening, it's very difficult for children to hear what adults are saying to them. The damage can be done between that period, so when the brains are effectively switched off from what's gone on, and factually, it's somebody responding from a emotional point of view, it's a survival technique, it's very hard to communicate at that point, but I think maintaining that drip, drip, drip of positive contact is important in that restraint and I think it is difficult, I think I've certainly been involved, you know, seen events happen whereby the behaviour escalates, restraint happens, the child gets worn out, effectively gives up, is then moved to somewhere that's a safe space and the same pattern repeats itself over and over again and for some children that's their way of communicating and understanding,

having contact with adults, which is totally harmful in the short and long-term. That's a factual thing.
Q. It's a further complicating factor of it?
A. Absolutely, yes.
Q. Moving on from restraint issues, Mr Wood, if I may, can I deal now with some points about the nuts and bolts, if I can call it that, of how allegations were investigated --
A. Yes.
Q. -- and pull up, please, 3.1.3, which is the same report but at internal page 8, where you refer here to two incidents where complaints forms have been completed, had highlighted sexual abuse but where both of the children denied completing the form. All right? So can you comment on what you drew from that and how that was dealt with?
A. Again, from examination of the records which were there, these two separate children made two separate complaints, both denied filling them out and I think for me, there is a lack of evidence, I suppose, in terms of what was going to happen next, then, so the form was filled out by someone and people -- I think the staff member seemed satisfied with the explanation that it wasn't me. Now, I suppose in terms of looking at the range of options children would have and I know the

Ministry of Justice has outlined a range of options in terms of the pathways to making an allegation against a member of staff or a child, the form is one of them, and I suppose, for me, it would have been helpful to understand a little more about whether this is a surprise to staff, this came as a common factor.
To me, it was left in that stage whereby the child was saying, "It wasn't me", and it is difficult. If a child is denying an allegation, then there is an end to that. You can't keep on trying to fish information. There is an end to it, but I felt that it would have been helpful to have a written explanation about what happened next, if anything.
Q. Because it could have been a retraction of an allegation, couldn't it --
A. Absolutely.
Q. -- rather than a mistake?
A. Absolutely right, yes. I think for me it would have been helpful to show how these things were actually sort of worked out. So making a decision to do nothing is still making a choice, and that's what happens, I think. So it would have been useful to show how the thought patterns are worked out, why the end result was that way, instead of just recording "Retraction allegation, denial", that was the end.

Q. And I think is this fair, if you go on to 3.1.5 in your report, you saw a similar pattern where complaints had actually been withdrawn, so withdrawal of complaints appear not to have been followed up in terms of analysing and evidencing the meaning of the allegation to the child, given the context of it being made and the reasoning why it was later withdrawn?
A. That's right.
Q. That's a similar sort of theme, is it the?
A. That's right.
Q. While we're dealing with this, you do say at 3.1.4 a perhaps general observation that I think perhaps permeates the YOI analysis about the use of complaint forms and the practitioner point, I think, that you pull out of this is that there is, as we heard from your evidence last week a difference between concerns, complaints and allegations that have a significance for your practitioner head --
A. That's right, yes.
Q. -- if you like, that perhaps doesn't carry over to a complaints form in custody. So please help us with what you have drawn out under that topic.
A. I think for me, it goes back to the Howe & Co recommendation, I suppose -- I think it was recommendation 9 -- in terms of having a way to manage

or a way to record in a clearly transparent, trackable way. And what I found really and what I experienced, looking at the entirety of this and the record, it's very difficult to track those things, understand what actually happened, so -- and I think for me also, from a complaints point of view, a complaint to me has a different outcome, a complaint under stage 1, stage 2 and stage 3 could be investigated, it may be deemed not to be substantiated at any point in stage 1 or stage 2 or stage 3, but I think for me the use of the word "complaints" when we're talking about allegations of sexual abuse, there is a gap there, to me.

A complaint may be against a member of staff who understands it would have to be recorded in a certain way, but there were examples -- may not have been in Feltham, but other institutions, I can't recall at the moment, but there were definitely examples whereby children actually spoke to a member of staff about an allegation and then he told them to fill out a complaints form.

Well, to me, it's that adult's responsibility to take forward that allegation and not -- it isn't very helpful to say to a child, "Stop where you are, fill out a complaints form", which may -- they may not be able to do anyway, but also may be worried about writing things

down and then -- it then goes somewhere else.

Q. Is that one of the examples of a sort of focus on substance not form that -- forgive me, form not substance, that you identified that there was quite an adherence to process that you seem to have pulled out as a key theme. Is that fair?

A. That's fair, yes and I think for me it's the -- it's the experience of the child is the most important thing, it's actually quite hard to spot that. I mean, forms can be filled out to whatever extent they're going to be filled out to and you may gain information from those forms, but I think in terms of the number of substantiated allegations which ended up -- whichever route was taken, was very low across all institutions anyway, so the outcome for children was hard to spot, I think.

So I think for me, the procedures are complex anyway. The inspection frameworks are complex and may not actually complement each other across the entirety of the span, so that's into the mix as we stand now and for a child to try to navigate their way through that actually is quite hard. So I think for me, there are advantages and disadvantages, but I think, for me, to have a system or a process whereby we can track exactly how many allegations were made against whom and when and

what the results were, that's the fundamental keystone.

Q. Moving, then, to some issues you had raised about the actual quality of the investigation when a disclosure had been made, 3.1.14, please, it's internal page 10 of that same document. I think there are several different points you made under this heading, and at 3.1.14 you pulled out that there had been two, I think historical allegations of sexual abuse made by adults in regards to staff at Feltham which had not been pursued. Tell us what your concern was about the way those had been investigated.

A. One of them was really about -- one route was that they advised some mental health professionals that it wasn't the correct thing to do to follow up that allegation due to the mental health state of the adult. I wasn't clear from the record in terms of what explanation was around that or what support could be put in for that for the mental health issues, so there's a gap there.

Now, it may be that's very standard advice and it may be the correct advice, but it would have been really helpful to understand how the institution responded to that, to say, "Well, that's the case, what we're going to do about this allegation".

The issue, the other issue, was that there was an issue in terms of a decision was made not to -- not

to pursue one of the allegations of historical background issue. I think for me, again, a rational explanation about why that decision was made and to work backwards from that was actually absent from the record. I think it may say, sort of later on in the report why that was.

Q. Then I think a second theme that you pulled out from the Feltham analysis was certain examples of records being missing or not being as clear as you would have liked and I think to understand this, please, if we go to 2.1.12 in that report, that's page 7, you made a comment about some missing records in relation to Werrington at 2.1.12. That's internal page 7, as I say. Just scrolling down to 2.1.12, you said:

"It is unclear from the records examined why a record of entry into a child's cell was absent was a particular concern, given that the child in question was perceived as being of high risk in regards to a propensity to make allegations against staff."

There were further points about an absence of recording, and then you're asked to look at that issue in the context of Feltham. If we go, then, to your fifth report, please, which INQ001764 and it's internal page 2 and scroll in, please, on paragraph 1.3 and thereafter. I think you pulled out a similar theme in

respect of two of the incidents at Feltham from December 2012 and June 2015. Can you help us with what your concern was about the lack of evidence here?

A. Yes, certainly. I think the issue in terms of a clearly defined pathway in terms of why decisions were made, which links into 1.5 in terms of the training and support given to individuals who worked directly with children and young people, I think for me -- it says, "I can further confirm the evidence of records examined" -- there were difficulties in terms of disclosure and allegations of sexual abuse and I think in terms of, for me, unless you get a very clear record in terms of what the response was, when a child actually alleged any form of abuse, but particularly sexual abuse in this instance, in terms of what processes were followed, what support was given, what advice was sought, external working together, those sort of things as well, it's very hard to spot where those things are.

And there were issues across some of the agencies, there are examples there. Feltham, I think, from my reading of the paperwork provided to me quite recently in terms of the standards there and the recent inspection there, seems to be doing one of those things, but obviously the period of time I was looking at is if the concerns were actually there, and there were

absences of records and this goes back to this issue in terms of the pre-existing awareness which members of staff have about children and young people and the risks they may or may not present. It wasn't actually utilised in a positive way.

Q. I think you have made a second point towards the end of 1.3 that there were some issues about an absence of CCTV coverage in relation to some of the incidents. Can you help us with what that was?

A. Yes, there were issues in terms of some of the instances of where I had CCTV, some of the decisions were made in terms of deciding not to put -- not to pursue allegations against members of staff. There was no CCTV coverage actually in the child's cell and that -- but one of the reasons to decide not to progress is that that wasn't there anyway. So it's quite hard to understand why a decision was made on the basis of it not being there.

Q. I think we heard some -- we adduced some evidence from the REA that a theme that had been identified by the research team here was whether or not there is, on occasion, an undue reliance on CCTV and I think what you're saying on that example is that the absence of CCTV was used as a reason not to pursue an allegation --

A. That's right.

Q. -- when it was in an area where there was never going to be any CCTV?

A. That's right.

Q. Is that your concern?

A. That's correct and I find that quite difficult to comprehend those two things together, really. So if there is an absence anyway, but there is no CCTV coverage there, then those two things are separate issues.

Q. I think Ms Willow's evidence last week was that her perception was that if there's not a CCTV recording or a member of staff corroborating a child's account, a child would find it very hard to be believed. Does that sort of fit a little bit with what you saw on this allegation?

A. I think so. I think in terms of the reliance upon CCTV coverage, these other examples in terms of it being quite hard to see the alleged incident on CCTV, because of the number of children around at the same time or the members of staff around, so there is a reliance on that, I think. I think -- and with the absence of that -- and I think one of the recommendations against for Howe & Co was the sort of cameras being issued to members of staff and I do understand the implications in terms of a child's right to having a private space and the

cameras may impact on that, but I think in terms of providing evidence and providing good evidence which is not one person's word against the other, that's probably the only way to do that.

So I think in terms of the very fact that there's certain areas within the institution whereby there's no CCTV, it would have been useful to see and the records -- which may not have been the records I have seen, it may be elsewhere in some other documents -- about how the institution actually managed the risks associated with those areas that weren't being covered by CCTV.

One example we looked at earlier in terms of the fact that a member of staff going into a child's cell where it was known that was a high-risk issue and no record being made, that adds another complicated factor to it. I mean, I would suggest that if there is no CCTV coverage in the cell, then records should be very accurate in terms of who went in, what for, how long for, who was there as a witness.

Q. To add to the objective pool of evidence about what happened?

A. Yes.

Q. Just finally on this topic, please, 1.52 of your fifth report, it's INQ001764, just bear with me a second. No,

sorry, yes, it's INQ001764_010, please. I think you return to the issue of CCTV at Feltham at 1.52 at the bottom of this page and over the next page, and I think a specific example you pulled out was the 9 September 2009 allegation where you said here that the decision not to pursue the allegation was made as the CCTV evidence did not support the allegation made, so there was CCTV for this incident.

But then you say:

"This is despite the fact that the record indicated that the footage was very unclear, given the distance and the large number of other children and young people in the area. The records do not indicate that the witnesses to the allegation were spoken to. In stating to the child or young person the seriousness of the allegation and the lack of evidence to support it, it can be argued that the message given to the child was one based upon a warning."

A. Yes.

Q. So is your concern about that, that CCTV was very unclear but was used as a reason not to pursue the allegation?

A. That's what the record indicated, yes, that it was very unclear and that was the reason why they didn't take it any further.

Q. And it didn't seem, from your perspective, that witnesses had been spoken to?

A. That's right.

Q. And I think you felt that the child might have seen this as a warning. Help us with what you mean by that?

A. I think for me, if a child alleged an incident and adults respond to that in terms of saying: well, we've got no evidence for that, and I think the words of the child were this is a serious thing you've said, it seemed to me from the record that in the absence of clear CCTV evidence, the fact that witnesses weren't actually approached or asked from what they had actually seen, the information was shared with the child, it was a serious issue to make an allegation against a member of staff and we've got no evidence to say this is true.

So I think from a child's point of view I didn't feel like it's important that you're given the scope to make allegations and we take allegations in a serious way and we're going to investigate them to the best of our possible resources. It did feel to me this is an issue to say whether the child was actually told this is not a good thing to do without evidence.

I think, for me, the impetus on the child really was the wrong way to handle that. The institution should have looked at we -- there is a gap here, why did we

make this choice? How did we communicate to that young person about the allegation isn't going to go any further? Well, the record didn't actually sort of show that.

Q. I think another example of a lack of documentation, albeit in a slightly different context, was brought out by you at 3.1.17 of your first report, please. It's INQ001210, individual page 10, please, and it's paragraph 3.1.17.

Now, this is a serious allegation of rape that had been made against a member of staff. You make the point here there was a very brief record of it. A section 47 strategy meeting was held within which the decision was taken that there was insufficient evidence to contact the local authority where the alleged perpetrator lived and I think your concern was not only that this wasn't followed up further, but that there wasn't a clear reason for why that was. Is that a fair summary?

A. It is a fair summary, yes, and, again, I think for me, if those records about decisions and processes were held elsewhere then that should be cross-referenced here, otherwise it looks as if on the face, looking at what's actually happened, a serious allegation was actually made, a strategy meeting was held in this circumstance and decision was made at that point there wasn't

sufficient evidence at that point, which, again, goes to the definition of what an investigation actually is, so is it internal, is it a LADO investigation, is it a social care investigation, is it a joint investigation, is it a police investigation, is it an investigation under section 47 of the Children Act? So it's unclear in terms of why that choice actually was made.

I suppose coming from a point of view whereby I would record things expecting the child to view the record at some point in the future, I'd want an explanation about why the decision was made.

Q. You have made the point in your fifth report, please, paragraph 1.19, it's INQ001764_004 that there were several similarly serious allegations among the paperwork that you saw. I think you have said at 1.19 that the record did indicate a serious allegation being made by a child or young person ringing Childline in respect of witnessing another child being raped by other children or young people in the shower.

And you summarise there the other serious allegations, particularly serious allegations that you had looked at, including a nursing member of staff sexually abusing a child during an examination, a custody member of staff during a search, a custody

member of staff raping a child or young person in the cell and those are, I think, a summary, is this right, of the more serious of the allegations that you looked at?

A. That's right, yes.

Q. You make the point that there were, I think, you say there, no substantiated allegations, albeit I think in fairness earlier you suggest that one --

A. One.

Q. -- of them was.

A. That's correct, yes.

Q. On 9 September 2009.

A. Yes.

Q. And you go on within this report, then, to deal with the Social Services involvement. Can I ask you to look at, please, 1.39 in your report. It's internal page 8 and I think you broadly said that just above 1.39, forgive me, in around 50 per cent of the cases from Feltham the Social Services or LADO had some involvement. Is that right?

A. That's correct, yes.

Q. But then you go on to indicate concerns, I think, overall about the section 47 threshold and about the substantive involvement of the LADO service so help us, please, with your themes about that?

A. I think for me it's the issue is linked to when the decision is made to refer to LADO or straight to social care, the process around from a LADO point of view in terms of the threshold they may want to apply to the information they have, from a social care point of view in terms of ensuring that section 47, the requirements are actually met.

I'll go on further to, I suppose, a bit later on the report, to say that given the additional risk factors and the exposure to risk and the past history of some children and young people, it's my view, I suppose, that section 47 should start as a default position and then work backwards from that with instances against allegations against a member of staff.

So I think, for me, it comes back to, again, in terms of this diverse range of responses and I suppose what was of concern to me was it may be the situation that in response to an allegation a child has made may take a particular route depending on who that allegation is actually made to, so the consistency of approach is hard to see. That's my overarching view, I suppose.

Q. I think if I can go, please, to the last but one page of that report, it's internal page 12, please, under heading 3. You pull together, I think, a generic theme was around the involvement of Social Services and the

LADO. You said at 3 that a generic theme was the use of internal investigations. Where allegations were made against members of staff the LADO was contacted although not present on one occasion at Werrington.

Investigations under section 47 were a rarity across all the institutions, but in comparison to Medway, Feltham appeared to have a low rate of substantive involvement from the LADO.

So that was one particular Feltham-related theme.

Is that right?

A. That's correct, yes.

Q. And then finally, please, help us with your evidence. If we can go back to 1.41 in the report, it's internal page 8, where you were asked some questions about the police investigation.

A. Yes.

Q. You have said here in Feltham none of the allegations were substantiated, none have substantive police investigations, none were subjected to section 47 investigations.

A. Yes.

Q. Help us with what you mean, please, by "substantive police investigations"?

A. Certainly, yes, I'm happy to do that. My perception of substantive police involvement was actually a section 47 approach, so I know one example's been given in terms of the police interviewing a young person, looking at CCTV coverage, analysing rotas, those sort of things, as well.

I think for me it is, from the records it actually is quite hard to see what actually happened to reach allegation which was made. I do take the point in terms of substantive police investigations may be the fact that they took their own investigation. To me, this again comes back to the difficulties in terms of trying to separate out what people mean by allegations, investigations.

Q. Who is doing what.

A. Who is doing what, and when and why. So I think in terms of the example given, I suppose, my view about substantive involvements isn't just attending a strategy meeting. That isn't substantive involvement from any agency; that's their statutory responsibilities to do that. So substantial involvement would mean to me in terms of undertaking a very clear process under section 47 of the Children Act. And, again, it's hard to see where that actually is tracked across all the documents.

Q. So is there a difference in the language that you're using, then, between substantive police investigation

and no police investigation?
A. There is, yes, and I think, for me, the investigating sort of process needs to be analysed under one view, so section 47 is the most convenient way to do that in terms of cross -- from agencies' point of view.
It links into, into me in terms of agencies undertaking their own internal investigations as well, so it is quite hard on each individual allegation being made to see who was involved when and why and what involvement -- what actually meant, but I do agree with the MPS's view that the example which they gave is example of police becoming extremely involved in a case. My understanding was that may not have been under section 47 of the Children Act.
Q. I think, in terms of your background, do you yourself have experience of conducting police investigations in custody?
A. I do. In terms of from my angle on that, yes, I would do, yes, so I have undertaken those. I mean, I have conducted joint investigations with police myself and police -- and joint investigations and that includes allegations against members of staff and also allegations whereby there's an organised view from abuse so wide -- a wide ranging group of adults, as well, within particular areas, as well.

I've also had to remove children from various situations with police involved, undertaken Achieving Best Evidence interviews and I've supplied to courts for a wide range of orders, which is -- normally is a consequence of the police exercising their powers to remove a child under extreme circumstances, so I have done those things, yes.
Q. So just trying to distill it, then, you remain of the view that there were questions, if I can put it neutrally, about the substantive police involvement in some of these allegations. Is that right?
A. I think, for me, the example which is given is a clear example of what they actually did. For me, without examining the entirety of records across police records, which may add additional factors, with the information I have seen, which I would expect, since a child's actually "resident", in inverted commas, there, that should be the core element of where all the records are actually cross -- sort of -- referenced from my perspective, anyway.
It is quite hard to see the level of involvement across a range of issues, not just from the police but from social care, from LADO, all agencies involved.
Q. Just one final question, chair, if I may, from Howe & Co, please.

You have heard evidence, I think, about the review of the pain-inducing techniques that has been carried out by the Youth Justice Board. Can you give a view from your own perspective of what you consider the effect may have been of pain-inducing restraint on children's willingness to disclose abuse and perhaps, more generally, from what you have seen in these case studies?
A. Yes, I'd be very surprised if a child responded in a positive way to understand that the reason why restraint happened, no matter how much you explain to a child the reason why, a positive response is actually quite hard to see afterwards. So therefore that would sort of show to me that a child's previous experience is based upon adults harming them, abusing them, trying to control them, which may be pre-existing, their experience from wherever they are, Feltham or Werrington or anywhere, it's going to add to their sense of adults can impose their power in a certain way.
It's not going to assist a child feeling comfortable or confident in talking to that member of staff about an allegation of sexual abuse. That's my perception. I mean, it is a very difficult role to do to restrain a child. No matter how careful you are, it does actually mean that adults imposing their power and

control over that child.
Q. Thank you. And just finally for completeness I should just read in the reference for the MPS material. It's OHY003322, and that's the example you were given of various steps the Met Police had taken on a particular --
A. That's right, yes.
MS HILL: Thank you, chair. Those are my questions for the witness.
THE CHAIR: Thank you. We will take a lunch break now and return at 2.00.
(1.05 pm)
(The luncheon adjournment)
(2.00 pm)
MS HILL: Thank you, chair. I will call, please, Glenn Knight.
MR GLENN KNIGHT (sworn)
Examination by MS HILL
MS HILL: Thank you very much. You're Glenn Knight; is that right?
A. Yes, that is correct.
Q. You're here to give evidence because, is this correct, until May of this year you were the governing governor at Feltham?
A. Yes, I was.

Q. You're hoping to assist the panel, I think, with some general background to the systems in place for safeguarding children at Feltham and also to try and assist with the response to some of the issues that Mr Wood has identified. Is that right?
A. That is correct.
Q. You have provided a statement dated 13 July which I will adduce, please, with your permission, chair, HMP000407, which sets out a bit of the background in relation to Feltham. Mr Knight, can you tell us a little bit about the two different parts of Feltham and what they are and things like that?
A. So Feltham has two sides, so it has Feltham A, which is where we care for up to 180 young people and that will be from the age of 15 to 18, and then it would have Feltham B, in which we'd care for, fully operational, 522 young adults and that would be the age from 18 to 21.
Q. Feltham A has young people who are both sentenced and on remand. Is that right?
A. Yes, it does.
Q. Then tell us a little bit, please, about the different units within Feltham A?
A. So on Feltham A you have an induction unit where all the children and young people would come initially. You

also have the living units where we would care for up to 30 young people on those units and just recently we have introduced an enhanced support unit, which is a small unit that would care for the young people, the most challenged and challenging needs.
Q. Help us, please, with whether children share a room or whether or not there are double rooms?
A. So the majority of the rooms are single. We do have some rooms that can be shared, but that would be on a risk assessment basis or a cell share risk assessment would take place, and that would normally be only with boys that have reached an enhanced level or if they're an insider and we felt like some additional young person would need additional support. But there are only one of those on each of the units and they're used very infrequently. And if they would be used, as I said, it would be documented and risk assessments would be taking place.
Q. I think, Mr Knight, you give a specific example of one of the double rooms being shared by two young people who had been at Feltham for a long time and developed a friendship and their sharing arrangement was agreed after careful consideration of their offences and their conduct in custody. You suggest that the process of doing that ensures that there were no risk indicators of

sexualised behaviour or self-harm. Is that right?
A. Yes, that is correct, yes, there will be a complete multidisciplinary assessment on both of those young people.
Q. You were asked some questions, Mr Knight, about the inspector's report of Feltham in 2017. If I could bring that up, please, it's INQ000125?
MR FRANK: Ms Hill, I wonder if I could ask you -- I am having difficulty finding this in my bundle.
MS HILL: Just bear with me a second. I understand that you have the statement for Mr Knight in your bundle. I don't think you have his exhibits or the supporting documentation. Just bear with me a second, please, I think you have his statement should be, it's section 33, tab D, the index may not have yet caught it up, I'm sorry.
MR FRANK: Thank you very much.
MS HILL: But I think the inspectors report I am about to go to is at tab C.
Thank you, if I could pull up the 2017 report. As I say it's INQ000125 and just to take this relatively briefly, Mr Knight, because I know this isn't the most recent report, could I pull up, please, internal page 5 which sets out a broad introduction to the report.
This was a report with Peter Clarke, HM

Chief Inspector of Prisons and, is this right, there were a range of concerns raised in the report about levels of violence and the use of force having increased, for example?
A. Yes, there was.
Q. Some of the violence was very serious. There was a concern about the restrictions on the regime and I think, by way of trying to pull the different threads together towards the end of this page, "There was an extent", it says, under the penultimate paragraph, "to which Feltham A was a place of contrast. There was no doubt staff working in very challenging circumstances yet most of the interactions we observed between staff and the boys were polite. Inevitably, relationships were hindered by the lack of time for meaningful contact because of the amount of time the boys were locked up. Healthcare was good. The work of the mental health team was good."
It goes on to say it would be wrong not to recognise the challenges faced by staff at Feltham A, but overall it said that violence was a serious problem:
"The current approach is failing to deliver that reasonable expectation and from the evidence available to us is actually making it worse."
And concluded over the page by observing at the top

of internal page 6:

"One should not be surprised at the failure to improve when a mere 11 of the 55 recommendations made at the time of the last inspection had been fully achieved. 34 were not achieved. Nine were partially achieved. I would urge the leadership at both Feltham A, HMPPS and the Youth Justice Board to study this report carefully and on this occasion to take its recommendations seriously."

Just going further through the report if I may, please, section 1 of the report, we can see summarised on internal page 13. That deals with safety overall and it's right, isn't it, that in the box at the top, "Safety overall", the outcomes for children and young people were poor against this healthy prison test. That was the result in 2017?

A. Yes, that is correct.

Q. Then, if one looks at internal paragraph 1.17 on internal page 23, please, the heading "Child protection":

"The findings of this report were that the establishment protects children and young people from maltreatment by adults or other children and young people", was the expected outcome, but against that measure 19 child protection referrals had been made.

The majority continued to relate to the use of force by staff. Evidence that investigations were delayed unnecessarily because some staff were confused about the procedure for notifying the establishment safeguarding team. The potential for delaying timely action to prevent further harm was concerning. The safeguarding team referred allegations to the LADO within 24 hours."

And there was evidence about the subgroup remaining useful but there was obviously a concern being expressed there that not all staff were aware of the child protection procedures. Is that right?

A. Yes, that's correct.

Q. There were various other parts of the report that dealt with issues such as the level of violence, support for victims and things of that nature, that I perhaps don't need to come to. But is this right, that Feltham has taken steps to try and address those findings and accepted the concerns that were expressed?

A. Yes, we did. Yes, we took all of the recommendations very seriously from memory out of the 47 that was connected to safety, 22 of them we achieved in the recent inspection and 15 we partially achieved and I think you can see from my statement that the "poor" score was actually improved to "reasonably good", so from a 1 to a 3, and that's pretty much because we --

a number of reasons, really. We completely relooked at our behaviour management strategy. One of the issues and concerns we had was around staffing. We did actually invest in some staff training but, more importantly, our own localised recruitment process, so that helped and there is a midpoint pay rise as well. So, in effect, prison officers get paid more to work on Feltham than they were in other establishments.

Q. Let's just perhaps deal with this as we can in your statement, please, it's HMP000407 and internal page 3, please.

Just to try to put a bit of flesh on this, Mr Knight, you have explained here in your witness statement that you designed an action plan -- that's exhibit GK1 -- to respond to the report.

A. Yes, he did.

Q. You have provided the most recent report at your exhibit GK2 and, in fact, I think you extract part of the report at paragraph 10. Perhaps we can just scroll in over the page on that. This report noted that work to support the boys was reasonably good. Safeguarding and child protection systems were sound. Instances of self-harm were lower than comparators. A clear focus on reducing violence led to an impressive reduction in assaults on boys and staff. Levels of violence were

still too high. Systems to challenge bullying and support victims required greater management oversight at unit level. A promising new behaviour management strategy was showing some early results. Use of force was proportionate, governance was good.

Then some other observations. So the outcome overall was that children and young people, it was a reasonably good grade on safety. Is that right?

A. That's correct, yes.

Q. You have indicated that in announcing the results of that further inspection, the Chief Inspector welcomed the work that had been done by Feltham. Is that correct?

A. Yes, he did.

Q. You have provided, at GK3, the press release to that effect. So just to help us understand a little bit, you've mentioned some of the recruitment issues and the pay issues, but help us understand a little bit more about the nuts and bolts of the action plan and what you have implemented.

A. So all the recommendations would actually be linked to an action plan, so we would look at those individually, but if I talk about the whole focus and the strategy, yes, we had two priorities. One was award safety and ensuring that all of the young people that we care for,

the staff and all visitors are kept as safe as possible and how we improved safety was we had a complete review of our behaviour management strategy. We also introduced a restraint minimisation plan.

We also need to actually get a sense of community because somebody actually said to me once, "You don't have an issue with violence at Feltham. You actually have an issue with conflict", and what we found is the children and young people did at times, understandably, given their age, struggle to deal with conflict, so we introduced the restorative justice and we got conflict practitioners that help then deal with conflict.

We also tried to get a sense of community, as well and anybody that has worked with young people would know that actually awarding sanctions, sanctions don't work, you have to have clear boundaries, but what we have realised is, actually, reward works more, so you have to reward somebody seven times -- sorry, sanction somebody seven times unless you give a reward. So what I would say is we have completely reversed our policy. So young people were rewarded if they behaved and kept boundaries, they were given the tools to deal with their conflicts and, on the whole, there was a sense of community. Our enhanced, sort of, earned privileges scheme, we introduced three levels, bronze, silver and

gold, but also a platinum level which meant the children and young people that would work as a community could actually do additional tasks like Duke of Edinburgh. So there was a complete change and refocus, and I must say the reason we would be able to do that, to be honest, because the second priority has always been resource and our biggest resource of anybody that works in an institution like Feltham is the staff and, without the staff given the correct tools to do their job, the right amount of staff that we had and motivated and trained, it's very difficult to achieve anything at all.

So those were the two priorities that I set, it directs the travel and I'm pleased to say the inspectorate recognised us.

Q. A few points of detail, you make the point in your witness statement at paragraph 12 that as at the end of June this year Feltham A was fully staffed. Is that right?

A. Yes, it was, yes, it's probably the first time I've ever known Feltham to be fully staffed yes.

Q. And you've indicated that around 40 staff members have taken up place on the foundation degree about which we have heard.

A. Yes, they have, so people have volunteered and are taking up those places.

Q. You've endeavoured, I think, to have the prison staff engage more proactively with partner agencies such as healthcare, psychology, the local authority and youth support services in a range of ways, is that fair?

A. Yes, it has to be a whole-establishment approach, multidisciplinary, completely.

Q. Then help us, please, a little bit with the safeguarding training that staff are given and the extent to which that is compulsory and fully complied with or the training is done, at least.

A. So we call it POELT, so prison officers who are new to the role now, we do our own POELT training for all those staff that work with young people. Safeguarding is a key part of that initial training, but of course we have existing staff, so we would look to do our own local training and raising awareness. As I have said in my statement, of course, would I want every single member of staff to ensure they have carried out that out? Yes, definitely. Are there some staff that it may not have happened because of sickness when we have put the training on? Yes, so should I say that 100 per cent of the staff have been trained in no but we do put an emphasis on that.

But also just raising awareness, so we have had the LADO come in and we have introduced themed briefings

once a week. So they actually give a briefing to managers and to staff.

Q. And you think that's led to positive outcomes?

A. Definitely, yes, I think raising awareness and raising training, because it's not about individuals, as I have said, it's a whole-establishment approach.

Q. I think you've indicated that the current child protection policy for Feltham which I think we have -- just bear a second, LOM000004_001, perhaps you could bring that up briefly. That's June 2015 but I think you have indicated that that is going to be updated in light of Working Together 2018, which you now have. Is that right?

A. There are more modern versions than the 2015, but the current one which gets reviewed annually, we have just been given the Working Together practice guide, so it's due to review in July and that's happening as we speak, yes.

Q. I see. Just for completeness, please, can I formally adduce, and just perhaps bring it up briefly, the action plan that you referred to, your exhibit GK1 is HMP000408. Let's see if we can bring that up, briefly. I think if you go to the next page, please, and the panel can look through that in due course, but just for completeness, it's fair to say that that has a series of

actions numbered in the left-hand column, and it runs through to some 81 different action points. Is that right?
A. That's correct, yes.
Q. We can see on it the target dates, who is responsible and things of that nature. The panel can look at that in their own time, perhaps.
A. Yes, they can.
Q. Your exhibit 2, HMP000409, perhaps the second page, that is the most recent HMCIP -- his inspection report from earlier this year, HMCIP, and we can see, if the panel look into that, internal page 5, please, gives the more positive overall response than the previous report. Is that right?
A. Yes, it does. It's actually showing the glossary of terms, I think it's the next page, actually.
Q. It's my internal page 5. That's it. Forgive me. The panel can, again, read that, but this is the report that you were no doubt pleased to see.
You have referred -- just to formally exhibit it, we don't need to bring it up, I think -- to the press release from the Chief Inspector. That's at your exhibit GK3, HMP000410. The headline is:
"HM YOI Feltham A. 'Children and young people significantly safer', says chief Inspector."

You've also referred to the safeguarding strategy. I will bring that up because the panel may wish to look at that. That's HMP000411. That's a September 2017, next page, please, sorry is the internal page 2. That's a September 2017 strategy for safeguarding. So it postdates, does it, all of the allegations that Mr Wood looked at?
A. Yes, it does, yes.
Q. Then, for completeness, please, HMP000413 and it will be the second page. This is a perhaps -- no, forgive me, sorry, it's 412, I think. This is GK -- yes, that is right, this is the perhaps allied strategy which is around restraint minimisation?
A. That's correct, yes.
Q. Then help us, please, with these last two documents. So GK6, which is 413, this is a new document agreed, I think, with the London Borough of Hounslow. So help us a little bit, please, with that?
A. I mean, so this is our local protocol that we have agreed jointly with the local Borough of Hounslow.
Q. What does this assist in the panel -- the panel in understanding, what does this apply to, how does it work in practice or how is it anticipated it will work in practice?
A. This just makes it clear that it actually sets out

levels of responsibility, who's responsible, Working Together across local authorities and internally, as well.
Q. I think you have dealt with this in your witness statement at paragraph 37 but this process applies, is this right, when a member of staff is the recipient of an allegation of sexual abuse and other things?
A. Yes, yes, it is, yes.
Q. The intention is that this will be reviewed in accordance with the most recent Working Together document, but its intention is to set out a clearer process for how to respond to allegations against members of staff?
A. That's correct, yes.
Q. And then, finally, your GK7, which is HMP000414 and it will be the second internal page in that. This is a risk assessment matrix, I think, an RAM that's been designed in early 2018, which was, again, referenced in the most recent Chief Inspector's report. What is your understanding of what this document does?
A. So this is a local document we introduced, just, again, for clarity really, so this is around setting -- it's looking at risk around individuals as well, so the risk assessment process could be if it's -- if there is a concern or an issue, but it's around training, that

could be highlighted, to the most serious concern where a member of staff may have to be suspended or obviously from police involved.
So it's just a framework in a document where we can actually manage risk and it can be documented almost like a decision log, really, around how we have come to the process of making those decisions around that individual case and member of staff.
Q. Is the hope that the risk assessment process here looks at both the needs and vulnerabilities of the child, but also part of this process is to consider whether or not someone should be suspended, it's to help make decisions of that nature?
A. Yes, I mean, the child has to be the centre of all of these processes. So, yes, it's a way of that being documented as well and, more importantly, evidence.
Q. If I have understood it correctly, if one looks at the document, this is a document that is filled in about a member of staff. Is that right?
A. That's correct, yes.
Q. And so it is a way of tracking how many safeguarding referrals have been made in relation to a particular member of staff. Is that right?
A. It can be used in that way as well, yes, so it will certainly be on record.

Q. I am just looking at the form. It has "Staff name" at the top?
A. Yes, it would.
Q. But this is about a member of staff, so it's to try to track, is it, the risk that they pose or are perceived to pose?
A. Yes.
Q. So if an allegation is made by different children -- allegations are made by different children against the same member of staff, this form should help capture that. Is that right?
A. Yes, it would, yes and obviously we would have that information and we could look back and track back and see how many times are there things that need to be done around training or is it repeat occurrences or are there serious concerns?
Q. And things such as their last MMPR refresher and actions that are taken about them are noted on this form. Is that right?
A. Any action that will be taken but that could be one example, yes.
Q. Your final exhibit, please, I think is your GK8 that's HMP000415 and that is a, I think in fairness, still draft service level agreement, next page, please, a service level agreement between the Met Police,

NHS England, The Havens and HMPPS about, if one looks in the middle of the page, responding to serious sexual offences within prison establishments in London. You can see the purpose is "to standardise the interagency responses to sexual offences within prison establishments in London."
So it applies to the adult estate as well, I think. Is that right?
A. It does, yes, that's correct.
Q. Do you have a sense of when this SLA will be finalised and operational?
A. To be honest, I don't, because I'm -- my new job now, I'm a sort of interim prison group director for the IRC, so I've left Feltham since May. I was just speaking to my colleague earlier and it is still being discussed, but it would be wrong of me to put an exact date of when it's going to be finalised, and I wouldn't be signing it, so it would be obviously the new governor of Feltham but I think we're talking -- we're talking weeks rather than months or years, so ...
Q. Is it your understanding that part of the rationale for that document is to give a clearer understanding of the roles of the various agencies involved when a serious sexual assault allegation is made in custody?
A. Yes, it is. Just needs clarity for all agencies --

Q. Can I just move now to some other of the points of detail that Mr Wood has raised. As you have heard, he's given various views about the use of the complaints form and I think he's accepted that complaints are but one way in which children might disclose child sexual abuse. Can you offer your perspective on this issue, please?
A. Yes, the complaints is just one source and, again, I think we have listed it in my statement but the children that we care for at Feltham have a number of avenues as well from their CuSP officers or personal officers, from education, from our social workers, healthcare, the IMB, our advocacy service from Barnardos, the list is endless. We've got youth workers, Connected Youth come in, Road Light, so we have lots and lots of individuals and lots of agencies and organisations that they actually could raise a concern to.
Q. I think you have considered whether or not the complaint form which is, in fairness -- I'm sure the panel understand -- a generic form that children can use to complain about anything, whether or not there should be a specific section about sexual abuse on the form, and what is the view that you have given about that?
A. So if I'm being honest, my view is I don't think that would be appropriate, would work, so these are generic

forms that young people can use and these are in view for everybody to take, so they can have free access to them and I just think having a box on there, I'm not so sure a child would actually tick that box or feel comfortable about it, so I just think we understand that it's a generic form, but there is another option, there is a stage 2, so confidential access.
Q. That's a COMP 2 not a COMP 1, is that right?
A. So there is a COMP 2, which is a confidential access form and we would provide envelopes next to those complaints, so actually they get sealed in an envelope and they can either be opened by the governor or they can also be to my boss, the deputy director of custody. So that's a form that no one has access to apart from very senior people.
Q. I think you make the point -- is this right? -- that if a COMP 1 is filled in, that the complaints clerk who receives those complaints does have child protection training and so should know to direct that sort of allegation of abuse if that's what's made in the complaint to the safeguarding team?
A. Yes, they would know to the safeguarding team child protection officer or, if a complaint was dealt with at a weekend, it would be the duty governor, because obviously they're the most senior person that would deal

with any safeguarding issue.
Q. But do you feel now that the process in place at Feltham is that if sexual abuse is disclosed via the complaint route, that the person who opens that will know how to direct that to the safeguarding team?
A. Yes, confident about that.
Q. Mr Wood has made some observations about the retraction of complaints. Can you help with that, Mr Knight?
A. The individual cases, some of them are historic, so I wasn't at Feltham at the time, but I can talk in more general terms. So what I would say is, if anybody has to sort of -- doesn't want to go forward with their complaint, we just wouldn't take that at face value. So now they would be spoken to by either their unit staff, certainly safeguarding officer, also could be social worker as well, but more importantly, I think Mr Wood's actually said it, we would look and ask other people around, as well, that actually care for and work with that young person. So we wouldn't routinely just say "Well, you want to withdraw that complaint? Sign here and it will be taken back". That certainly wouldn't happen now.
Q. Do you feel the approach is more robust now than it was at the time of the allegations Mr Wood was looking at?
A. I can't comment.

Q. More nuanced perhaps rather than robust?
A. In general terms, yes, yes, I would. What I can say is, am I confident about the way that we would approach complaints now? Yes. I can't comment on 2009. But what I would say is, yes, I think our systems are more robust now, in my opinion.
Q. Help the chair and panel, please, with understanding the role of the dedicated social workers at Feltham?
A. So they are dedicated social workers at Feltham, they come from our local authority. We have currently got three in post now. I was -- one of their responsibilities is -- obviously is to look after those that are looked-after children, but also to deal with any safeguarding issue or complaints. They would have a case load and they would speak to the individual children and also speak to staff as well and just there for general advice, as well as have case loads.
Q. Has the provision of dedicated social workers changed in the last couple of years or has that always been in place?
A. It's always been in place but, like everything really, sometimes there have been gaps around recruitment, but I'm pleased to say that, yes, there are now three at Feltham.
Q. Do they provide support as part of the options for

support to a child who does disclose abuse?
A. Yes, they are one of the key people that could offer support and do offer support.
Q. If a disclosure of sexual abuse was made by a child at Feltham now, or at least relatively recently, how do you think that would be responded to in terms of the support given to the child?
A. So the support given, obviously, the complaint, the allegation would be made. That would be done, obviously given to whoever it's dealt with. The immediate concerns would be about keeping that young person or child safe, so how would we do that? So a risk assessment would be -- a process would be put in place but, more importantly, about what impact that child having to make that complaint would be, so you would look at how you could support them and it may be that they have already got close links with our healthcare, maybe our psychologist team. It could be they're already linked in with our embedded social work team, so you would look to see who could possibly support them and what I would say is the general staff, as well, so everybody would be looking to support that young person, that child.
Q. You say at paragraph 27 of your witness statement that in terms of the more substantive response to the

allegation:
"I am confident now that Feltham would respond robustly if an allegation was made."
Just help the panel with why you say that.
A. I would say that just because we have had independent scrutiny from the inspectorate, I mean, they have actually said it in their processes. Also, as well, we have a -- our local authority, our LADO as well as people that work in the local authority have access to keys to Feltham, so we have a number of times that they come in and do internal audits and they have free access, so assurance processes I believe are there. I mean, I think from our policies and procedures now, they are robust, they are reviewed and they do get reviewed.
Q. Part of the changes that you have described has been the different approach to restraint as we have seen and I think you have made the point that there is quite a different process in terms of responding to a restraint incident than there was in place in 2015. Is that fair?
A. Yes, there is. I mean, you've heard a lot about MMPR and introduction of that which we know obviously has a focus around the child. Staff get refreshed on that every six months not every 12 months, but if there is

an issue, and if there is a restraint, immediately now, depending what would happen, they will already be seen by a nurse and the duty governor. Then there would be very quickly a follow-up debrief from a member of the safeguarding team and from that, you know, I also chair, as the governor, or the deputy governor in my absence, a weekly governance meeting where we would look at all the incidents that happen on Feltham A and one of the key questions would always be, what support mechanisms are in place for this child? Is there issues to support the staff, as well, is it a training issue? Is it a serious concern? Is it a CP? Have we referred it out?

So that is minuted --

Q. That means it is a child protection case?

A. Sorry, child protection case. So all of that would be minuted and all of that would be documented in that weekly meeting, but prior to that, all of the MMPR coordinators and safeguarding officers would have already spoken to that young person and, again, it could be that if that young person has had a number of times and there has been a restraint, so we would look at -- we would look at the situation around that. It could be, if they do have an issue with anger or dealing with conflict, we have a whole suite of interventions that we

could try and help that child to deal with that, or if it's a specific concern around a unit, individual members of staff, of course we would look at that as well.

What I would say is there is a government structure that's highlighting inspection now, where we robustly monitor all of these complaints, and the child is centre in all of that.

Q. I think you make the point, at page 12 of the most recent inspectors report, that Feltham processes for governance around restraint were commended?

A. Yes, they were. Yes.

Q. You have made the point in your witness statement that staff do receive training on the complex needs and vulnerabilities of children and are trained to use physical restraint as the last resort in this context. Is that right?

A. Yes, it would always be the last resort.

Q. And you've made the point that if, as governor, on reviewing any restraint incident, you were concerned about the use of force, you would convene a strategy meeting and follow the child protection process. I think that when you said, "Is it a CP?", that's what you meant. Is that right?

A. Yes, we would. Or, yes, I would.

Q. Is there anything else that you believe is necessary for Feltham to improve its systems for responding to allegations of sexual abuse?

A. I think we could always improve. I do think actually the new 2018 Working Together, I think our policies do have to be reviewed and refreshed around that. I think we can only ever keep doing what we're doing to actually ensure that every member of staff, every young person and child and visitor has an understanding about this policy and, more important to me, certainly know how to signpost or flag it up. Again, our support mechanisms, would I like more social workers? Of course I would. Would I like more staff so we could interact with young people? Of course. You have heard about reform. Resources coming more to YOIs now and we're starting to see that. So I wouldn't say, yes, we have got there and we can't improve, because I don't think you could ever improve, certainly around this subject -- enough, sorry, improve enough.

MS HILL: Chair, those are all my questions.

Questions by THE PANEL

THE CHAIR: Thank you. Mr Knight, could you help us with something you mentioned: pay levels and the fact you were able to raise them in order to attract staff at one stage. For our information, could you say something

about, is there parity between the pay scales and conditions in the public sector and the private providers in this area?

A. So I -- I can't comment on the exact salaries in the private sector, but I can comment about Feltham, so if you looked at the local labour market, yes, there are a number of private sector establishments, Bronzefield amongst others, that were paying more, but probably one of the biggest issues that we had at Heathrow Airport, so of course it was the labour market around that, so our attrition rates were fairly high, we couldn't attract and retain staff, so we have now realised that and there has been a process and an increment and a midpoint pay range to ensure that we do get the right people and that's in line with the local labour market and specifically around Feltham and working with young people.

THE CHAIR: And you have no idea what private providers pay?

A. It would be wrong of me. I would be guessing if I said it.

THE CHAIR: Is there interchangeability across the sectors, in terms of people moving through from one to the other?

A. So, yes, not -- so you would have to resign from the private sector and then come to the public sector, you couldn't be seconded or just moved across.

THE CHAIR: No, no, but is there movement of staff?
A. Yes, yes, I have seen -- just locally, I do know of staff that have come to Feltham from private sector establishments, yes.
THE CHAIR: Thank you very much.
Ms Sharpling?
MS SHARPLING: Thank you. Just a question from me. The complaint forms that you have mentioned whilst giving your evidence, are they actually retained on personnel files for a certain period of time? I'm just thinking of those circumstances where, for example, the complaint has not been substantiated or not upheld or dismissed or whatever the action is, are they then retained on the personnel files for a period of time?
A. So the complaint form is one that a young person/child would complete. They wouldn't be retained in personnel files. Our personnel files now are all done electronically. What would happen is, let's just say there was a local investigation or the police are involved, there would be a note of that if an award was given on individual records but there wouldn't be around on personnel files to say --
MS SHARPLING: What happens to the form in the end?
A. So the form will be kept by our complaints clerk and will be filed and then it will be kept for the period of

time we have to keep it, and eventually it would be destroyed and put on our sort of destruction log to say that this information's been destroyed, but that would be in five, ten years' time, it certainly wouldn't be in the next short term.
MS SHARPLING: All right, thank you.
THE CHAIR: Mr Frank?
MR FRANK: Just a question about the social workers that you mentioned. You say you have three, I think?
A. Yes.
MR FRANK: What's optimum?
A. So, I mean, if there is optimum -- for me, I think we could always -- we could use double that, treble that but, again, I appreciate it's difficult in the community, as well. So if you was -- if you were talking about me, I would say, yes, actually, my view, five or six would be really, really useful, but I do recognise the scene around, sort of, public funds and the community as well.
MR FRANK: One of the things you mentioned was that, I think, they tend to have a direct involvement with those who have already been in care, as it were.
A. Yes.
MR FRANK: And so, if there is a shortage of social workers, it's the ones who have come from the care background who

are most likely to suffer from that shortage. What can be done to increase the number?
A. What, in Feltham, or in general?
MR FRANK: So let's deal with Feltham, which is ...
A. Well, I guess this is probably somewhere above my pay grade as the governor, as the governor then, so this is a policy decision that people just need to consider about where are resources best placed, so I think it would be wrong of me to be able to say how it could be done, but I think certainly there's a legal analysis as well but, corporately, I understand, as you say, if we get additional social workers in Feltham and the overall budget isn't increased, then somebody else has less.
MR FRANK: I won't press you on what you can't answer. Thank you very much.
THE CHAIR: Thank you, Mr Knight.
MS HILL: Thank you, Mr Knight. Thank you.
Chair, just before Mr Wood returns I should indicate that there is a written response that's been provided to the inquiry on behalf of Hounslow who are the appropriate local authority for Feltham. I don't think time today is going to permit reading in that evidence, but please can I just formally adduce in particular the witness statement from Lara Wood, head of safeguarding and quality assurance for the

London Borough of Hounslow, dated 2 July.
It's HOU000018 because that is Hounslow's detailed response to the points Mr Wood has made and in due course I'd ask you, chair, to read that.
For completeness, can I also formally adduce some earlier statements from Hounslow with the following references: HOU000002, 000004, 000001, 000017 and then in fact Hounslow had also provided the draft protocol about which we heard at 000020. In particular as I say, chair, it's the response of 2 July that I'd ask you and your colleagues to read in full.
So I will recall, please, now Mr Wood to move on to deal with some issues around Werrington and, chair, what I propose to do is ask Mr Wood some questions about the themes he identified in relation to Werrington. Then perhaps that might be the time for our break and then we will hear from Mr Gormley about Werrington.
Thank you, chair.
MR ALAN WOOD (continued)
Examination by MS HILL (continued)
MS HILL: Mr Wood, help us, then, with some of the themes that you identified from your review of the allegations at Werrington. First of all, if I can ask you to look, please, at paragraph 2.1.7 of your second/third report. In fact, forgive me, before we get there, can I ask you

to turn up the list of allegations in relation to Feltham. It's at -- Werrington. It's INQ001210 and it's internal page 5, please: if we scroll in on that, top of the page, please.

We will see there that you were invited to look at ten issues, is this right, in relation to Werrington?

A. That's correct, yes.

Q. I will just wait for that to come up. INQ001210, it's the report we had earlier.

Second and third report. Sorry if I gave you a bad reference. It's internal page 5, please, and just scroll in on section 2.0 at the top. That is the list of dates of allegations that you looked at, so it spans here a period from January 2011 to March 2016. Is that right?

A. That's correct, yes.

Q. If we scroll in, please, on 2.1.1, go down there. Generally, is this right? At 2.1.1, you said:

"With the exception of one allegation, Werrington responded to allegations in a timely and structurally appropriate way. There was good evidence of the allegations being recorded in an appropriate manner using the correct form. Generally, the recording was clear and concise, but there were some issues, perhaps, about the quality and appropriateness of the language

used."

So just help us with what you meant by that?

A. Yes, certainly. I think in terms of an overarching point of view, the records within this young offenders' institution were of a high standard. They did show what actions were looked at and what the next steps were.

I think for me, again, it reflects on other comments I made earlier that the consistency in terms of the good recording practice wasn't always matched in terms of the analysis, understanding of children's needs following on from that.

Q. So there was a better process here, is that right?

A. That's correct, yes.

Q. But there were still some concerns about the nuanced understanding of the children's needs?

A. That is correct, yes. I think this institution tended to follow one set way, so it was easier to match up those initial views, as well. So I think for me, still, the common theme really was that, even though the recordings were there, there is still some issues in terms of what it meant.

Q. One of the themes you pulled out, if we can go to the next page, please, internal page 6 and scroll in on 2.1.7 and 8, one theme you elicited was a suggestion of allegations being regarded perhaps with suspicion. So

help us with that, please.

A. Yes, a couple of examples, I suppose. In terms of a child's past use of the complaints procedure -- so there were some examples in terms of whereby the view I had was, was that sometimes the response may have been framed by the view that there is a suspicion regarding the purpose of why the child has wanted to make a statement.

I think one example I drew out says there is a significant potential for a disclosure not to be a genuine one and that statement was made prior to any investigative -- or any breakdown of what had actually -- the allegation actually was.

So in its sole context without any meaning behind that, that's quite a stark statement to make in terms of being significantly potential for the disclosure not to be a genuine one.

Now, that may have been reflective of the person filling out that particular record of his or her experience, but, without the additional context, actually quite hard to grasp the reason why that statement was actually made.

Q. Just for completeness, if we can turn up, please, INQ001764, internal page 2. That's where you gave some specific examples, I think, of this theme in operation.

It's the first two paragraphs on this page, please, 1.1 and 1.2. You were asked specifically about certain allegations there, those referred to on the notes SFC000007 and NOM000009, and I think you indicated that they were examples of this sort of suspicion in operation. Is that right?

A. That's correct, yes.

Q. I think, just for completeness, we can pull up some examples of that from the letter of instruction where the documents were quoted. It's INQ001733_001, please and you can see, if you scroll in on the bottom paragraph on that page, please, the extract from one of the documents here, (i), I think, where there is reference to what the allegation was, that "A female officer touches my bum and my dick and grabs me during searches on visits". The initial note from the head of safeguarding said, "I have some doubts as to the credibility of the complaints, as both boys chose to submit them on the same day", and there are various other reasons why it was thought to be lacking in credibility.

The LADO has said:

"I agree this invites some suspicion about the genuineness of the allegation."

Then over the page, please:

"An unidentified person had told Childline that he had been informed by a person recently released from Werrington that a 16-year-old had been raped while detained at Werrington by another inmate who was from a rival gang because of the young person's gang affiliation. The referral said inmates from other gangs and the young person's own gang were planning to target and assault the young person for informing on them."

And an observation was made:

"It is quite possible this is a malicious referral that needs putting to bed one way or another."

A. That's correct.

Q. That's the sort of thing that you felt exemplified this theme?

A. That's right, yes.

Q. Going back, please, to your report, the first report you produced on Werrington. You had also raised concerns, I think, about the lack of records in some areas. This is 2.1.12, so it's INQ001210, internal page 7, please. Scroll in on 2.12, please, I think it's a paragraph we have looked at before.

A. That's right, yes.

Q. Just help us a little bit with the detail on that, Mr Wood.

A. Again, this is the one where there was some issue

regarding why a record wasn't made about the entry into a child's cell, and there were some prior experiences of this young person being at high risk in particular areas. So I would have expected, if there was some pre-existing awareness of this child, that a very clear record of why the entry was made, who was there, what happened and what happened afterwards would have been there for me to look at, which wasn't there.

There's no context round that either, so there's no reason why that record wasn't made. It just says it's not clear why it was missing.

Q. I think if we can pull up, please, INQ001764_002 and scroll in, please, on paragraph 1.3, you confirmed again certain other examples of this lack of records in operation. Scroll in on 1.3, please, from NOM000009 relating to those dates, 18 November 2011, 18 March 2015, 24 February 2016, and 20 March 2016 were the Werrington examples, I think, of an absence of records --

A. That's right.

Q. -- that you'd have hoped to see?

A. Yes.

Q. You, I think, have made observations about the delay in responding to some allegations. Is that right?

A. That's correct, yes.

Q. And if we wish to see that, that's in your fifth report at paragraph 1.21, so that's INQ001764, internal page 5, please. Forgive me that's a bad reference, sorry, just bear with me a second.

Forgive me, I will go back to the Werrington section at internal page 2, please.

I think in this section you were asked to pick up several themes, perhaps deal with it in this way: 1.6 on this page, please, you raise some points about the nature of the investigation of some of the allegations at Werrington. What were the themes that you pulled out there, Mr Wood?

A. I think this is where the definition of what you mean by "internal investigation" comes in, as well, so there were examples whereby decisions were made for an internal investigation to happen and I think, for me, it would have been really helpful if it was explained about why that choice was made, what that meant, who would actually speak to the child, what the outcome of the investigation was, what the issues were, what the potential was as well, and what would also happen if the internal investigation highlighted that it was needed to be externally examined as well. Those things weren't there, so I think in terms of the choice made in terms of which route to go down, I think sometimes, for me --

the LADO perspective as well, there is an issue into, if the LADO says there is no need or there's no requirement for investigation to go through that route, then it's pushed back then in terms of the institution to complete their own internal investigation at that point.

I suppose, for me, the loop then has slightly got a gap in it, really, in terms of what happens then as investigation highlights any other issues?

Q. Perhaps we can go, please, to internal page 9 in that report so it's INQ001764, internal page 9. At the foot of the page, you were asked about some specific allegations and how they're investigated. Perhaps the panel can just scroll in on 1.45 and the following page. I think for each of these -- and there are, I think, five or six different dates, so it's 1.45 through to 1.51, perhaps the panel can just scroll in on that -- you fleshed out why you felt there had been a lack of full investigation for some of these issues. Is that right?

A. That's right, yes.

Q. So you picked out, for example, themes where -- 1.46 by way of example:

"8 April 2013, CCTV was used in the area where searches took place. Two members of staff were present. There is no record of the CCTV being checked and that

anyone else present during the search was questioned. The boys appeared to withdraw the allegation once an explanation was given to them in regard to the thorough manner the member of staff concerned undertook the searches. There is a relationship here between the experience of a child in relation to how any allegations are received and managed and communicated about and the likelihood of retraction, given a lack of trust and confidence."

There are various other points of detail that you take the panel to in relation to other allegations but of a similar sort of concern. Is that right?

A. That's right.

Q. Just bear with me a second, to see whether I need to bring this one up. I think a related point, perhaps, is at 2.1.11 of your first report. That's INQ0001216_007 at 2.1.11, I think as well as a concern about qualitative investigative steps, if you like. There was a concern at 2.1.11 about contact with members of staff once allegations had been made against them. Is that right?

A. Yes, that is right, yes.

Q. Just help us a bit with what you said about that, please -- sorry, it's INQ0001216 -- is it? Or is it my handwriting? Is it 1210? That's why you can't find it,

sorry. 1210_007. It's 2.1.11, please: what was the issue that you identified there about contact with children and the staff member in question?

A. That was the issue really, I suppose. When a child's made an allegation against a particular member of staff, to be clear about what would happen and how they're going to try to manage the issue, that member of staff may come into contact with that child, where the member of staff has moved to a different unit or whatever, but I think for me there wasn't much evidence on this one in particular in terms of how they're going to try to work with that risk. So from a child's point of view -- I mean, the member of staff could obviously be told not to discuss anything about the allegation which has been made, but from the child's experience, to see that same member of staff would be difficult.

Q. Then if we just scroll down on that page, please, to 2.1.16, I think we deal here with this particular allegation which I think is an allegation that a 16-year old boy had been raped by another detainee in the context of a gang --

A. That's right, yes.

Q. -- situation. What was your concern about that particular allegation and its response?

A. Whilst I accept that the young person was completely

denying the attack actually happened, I think the way in which he responded to the information being shared with him did raise some concern for me.

I think also it would have been helpful, I think, if the record indicated an awareness of the fact that there could be a relationship between the state of the young person, the risks he was experiencing, the control and also the shame element and the power of gangs in terms of controlling children and young people.

I suppose, for me, the other issue was that, I mean, I appreciate completely if a young person is saying, "No, it didn't happen and the allegation is completely untrue", and it's not appropriate to go back over and over again the same issue. What would have been helpful, I think, is, given the context of the gang -- and the information's quite detailed from the outside in terms of this issue -- it would have been quite helpful to record at least that young the person's given the opportunity to come back to the issue if he wanted to or if there is some information to be shared with him about the impact of gangs upon people and how to recognise the signs of control and that.

So I accept that the young person said it didn't happen. However, I think it would have been helpful, given the context and the height and risk around these

issues, that the door would have been kept for him to push it and to then talk to a member of staff after the incident.

Q. I think more generally, if I can take you, please, to INQ0001764, internal page 2, please, and scroll it on to paragraphs 1.5 and 6. I think you have made the point that there is a need for staff to be trained in how to work directly with children in terms of responding to their allegations in a way that doesn't then impact upon any potential criminal or civil proceedings, so what's your point there about that, Mr Wood?

A. I think in terms of the likely range of experience, skills and attitude of staff members working in any institution, it's important to think that people are given tips and techniques about how to respond when a child does actually explicitly say something's going wrong in terms of an allegation or the more tricky one, I suppose, is in terms of children starting to drop hints around issues, behaviour starting to change, their relationship with other people starting to change. So it's being open to the idea of things, which is a difficult one for institutions to accept that sexual abuse can happen here and sex abusers look like everybody here. So I suppose, for me, there's quite a big leap in terms of institutions accepting the fact

that there is an inherent risk, when you get adults and children together, that some people are purposely trying to gain access to children and young people. So how you respond to that is important and how you respond to children and young people in the absence of allegations is important as well because that sets the context for your relationship with them.

And I think the recent developments from other young offender institutions whereby the relationship practice angle is starting to be built up, that's really good to hear because that's the basis of children feeling confident that allegations will be taken in a serious way.

It also creates -- I think from a staff training point of view, it creates the atmosphere and the approach in the unit whereby allegations are less likely to happen because abuse is less likely to happen. So there's a relationship between those two things.

Q. Then finally a few points, please, about the role of the local authority here, 1.38, please, of your fifth report, so if we can go, please, to INQ001764, internal page 7, to your fifth report and scroll in, please, on 1.38 at the bottom.

Just to anchor this, Mr Wood you were asked here about the procedures as set out in the London Child

Protection Procedures and so on for responding to allegations and you say at 1.38 that these are some examples where you feel the fact that the victim was in custody may have influenced how that allegation was responded to compared to had they been in the community. Is that right?

A. That's right, yes.

Q. We can take the panel through here, under (a) in relation to Werrington:

"An alleged physical and sexual assault and associated threats of violence were reported to Social Services but were then deemed not seriously enough to reach the threshold for investigation."

It appears that the separation into two single cells of the two boys concerned was perceived as a sufficient response and reminding the victim of his right to contact the police:

"In my opinion, the behaviour of the alleged perpetrator would have warranted action linked to the need to assess sexually harmful behaviour and, as such, the needs of the victim and perpetrator should have been assessed as part of a multi-agency plan."

Under (b):

"An alleged sexual assault by a member of staff during a search was referred for a strategy meeting but

the LADO did not attend. The outcome was unsubstantiated. There was no explanation as to the reason for the LADO's absence or if the LADO's views had been sought in relation to the outcome. In my opinion the absence of the LADO was grounds for the meeting to be suspended until the LADO was available."

And then the third example you give:

"An alleged sexual assault by a member of staff during restraint within a cell was not referred to the LADO or Social Services. The key driver appears to be the deputy governor was present during the restraint and the young person had said he was naked, whereas he was wearing boxer shorts. In my opinion, there were grounds to refer this alleged sexual assault to the LADO."

A. That's right, yes.

Q. You've, I think, repeated here in this part of your report the evidence you gave earlier today about how you consider the default position should be that a section 47 inquiry is undertaken in relation to a child in custody. Is there anything further in the context of Werrington you want to say about that?

A. I suppose, as a generic comment, that I think it would be helpful, given the additional needs of children and young people who are in custody, that we talked about earlier last week and also earlier today, that the

starting point should be that and then a clear explanation about why that is not the right route to be written down.

Q. Then, just for completeness, over the page, please, internal page 9 at the top of that page, you have confirmed from your analysis of the Werrington material that none of the allegations were substantiated. A small minority had substantive police investigations but none were subjected to section 47 investigations. Is that right?

A. That's what I understand from the record, yes.

Q. Is there anything else about the Werrington material that you feel I need to pull out to assist the chair and panel, Mr Wood?

A. Just a generic view. I think, also, just in terms of the London Child Protection Procedures, I think it's 3.3.2 in those, it does give a very clear definition of when section 47 should actually happen and which then aligns to my earlier point in terms of that being the default position and working backwards from that, so it's useful, I think, just to remind yourselves of that, actually. It is quite clearly defined in terms of a suspicion or allegation against an adult, so that's --

Q. I think the theme that you have identified is that they didn't seem to be happening enough across these two

institutions at least. Is that right?
A. Yes, that is right. I think one of the other issues, as I said before earlier today, is that explanations, records, connections, cross-referencing may be evident elsewhere, but it wasn't that clear in the records I looked at.
MS HILL: Chair, I'm not sure if you have any questions for Mr Wood on the Werrington paperwork?
THE CHAIR: No, thank you. Thank you very much.
MS HILL: Chair, that might be a moment to take our break and we have one more witness after the break.
THE CHAIR: Yes, we will return at 3.20.
(3.07 pm)
(A short break)
(3.20 pm)
MS HILL: Thank you, chair. I will call, please, Peter Gormley.
MR PETER GORMLEY (sworn)
Examination by MS HILL
MS HILL: Thank you very much. You're Peter Gormley; is that right?
A. That's correct.
Q. You were governor at Werrington -- again, is this right? -- until April of 2018?
A. Yes, that is correct.

Q. So again, rather like your colleague, Mr Gormley, you're here to give the panel some broad evidence about the systems in place at Werrington in terms of child protection and sexual abuse issues, but also to provide some response to Mr Wood's evidence. Is that correct?
A. Yes.
Q. Help us a little bit, please, with some background then about Werrington?
A. So Werrington is one of the public sector young offenders' institutes. It's one of the smaller ones. We lock up 118 or we care for 118 children, maximum.
Q. I think I have read about 110. Is that right?
A. On average 110, we can go up to 118. There are three main units, which is residential units in the establishment, two of which, A and B wing we call normal units and the third one, C wing, which is our care and separation unit and also offers an induction with an element of enhanced provision for children that are on gold regimes.
Q. A care and support unit in C wing has eight cells for segregation for people away from the main wings; is that right?
A. Yes, it does.
Q. All of the young people are housed in single cells across all the wings; is that right?

A. They are, yes.
Q. You have a dedicated social worker and a dedicated senior social worker employed through the local authority, and you say this at paragraph 7 of your statement:
"They are in place to provide external scrutiny to the Child Protection Procedures and ensure that all looked after children are supported throughout their time in custody. All young people arriving into Werrington meet with their dedicated social worker on-site."
A. That's correct.
Q. Looked-after children are obviously children who are coming into care in that category. That's not all the children in care, is it?
A. No, it's not, but children that come in on remand are considered to take on looked-after status, so a fairly large proportion are.
Q. So those children will automatically meet a social worker, but children who are sentenced won't automatically be seen as looked after. Is that correct?
A. That's correct. They will -- the social workers form part of our induction, so the child's induction into the establishment, so the social workers will form part of that. So they will meet them.

Q. So all children will be made aware of the presence of the social workers; is that correct?
A. Yes.
Q. Forgive me, Mr Gormley I should have formally adduced your witness statement of 13 July HMP000405, with your permission, chair.
You were asked some questions about the February 2017 report on Werrington, especially around the safety and safeguarding findings, and you, I think, have, rather similarly to your colleague, pointed out that there is a more recent report from earlier this year that is more favourable. Is that right?
A. In terms of safety, it's a similar score, it's the same -- it hasn't gone up or down.
Q. Let's perhaps just bring up the details, if we may. Let's go first to the 2017 report at INQ001457_001. Perhaps let's go within that to the introductory narrative, please, on internal page 5. This is your May 2017 report, we will just perhaps scroll through it. It makes the point that there was by this point in the third paragraph -- well, in fact, let's go to the first paragraph -- that at the previous report in October 2015 there were concerns about the safety at Werrington, although in all other respects outcomes were reasonably good or better:

"We indicated our confidence then that the management team would improve outcomes in safety."

And the third paragraph makes clear that by this point there had been an improvement in the children's perception of safety. It was clear that managers and staff were working hard to reduce violence which was evidencing some success.

And there were various other observations made. Some points, for example, about access to telephones being limited and that causing some friction. Time out of cells for boys was reasonable. Ofsted assessed the overall provision as good. I think the conclusion on this page was that, "Werrington, like other young offenders' institutions, faces some tough challenges and works with boys who can be very difficult, but it continues to do well. It was well-led with coherent innovative plans and initiatives helping to create a much more positive ethos in the institution than we see elsewhere. The priorities for Werrington include further reductions in violence and work to sustain the resilience of the staff group so that they can build upon the progress they have made."

Just bear with me a second.

I think if we can go then to your exhibit PG1 which is at HMP000406 and go to the second internal page of

that, please, we will see that this is the much more -- well, a more recent report from earlier this year, and if we go, please, to the March 2018 introduction on page 5 internally, and one can see -- just go to the last paragraph, please, on that page:

"In conclusion, it is pleasing to be able to publish a very positive report about a YOI. The inspectorate always welcomes good practice being identified and promulgated, which is why we have gone to particular lengths in this report to do so. It is clear that if progress that has been made at Werrington is to be consolidated and maintained, there needs to be a continued and unwavering focus on reducing the violence that is the major threat to its continuing stability and success."

If we go further up in that narrative to the third paragraph, there was a concern, it says:

"Our major concerns were around the levels of violence which had risen since the last inspection and were too high. There had been a significant increase from 142 to 206 incidents in the period leading up to this inspection. There had been an increase in the use of force and, in light of this, it was disappointing that body-worn video cameras were underused. Nevertheless, there were good initiatives in place to

tackle the violence and early indications were that they were having a positive effect. The ambition was to make the YOI safer but not at the expense of the regime. These efforts are detailed in this report."

If we go to the very top of that page, in January 2018 it says:

"We found not only that standards had been maintained. In the area of respect they had improved and now merited our highest assessment of 'good'. By any standards, this was a good inspection."

So although that was there ongoing concern about safety and in fact that element having got worse or levels of violence having risen and use of force being high, overall this was a positive inspection. Is there anything else that you would like to add on that, Mr Gormley? You have given some evidence at paragraphs 8 to 12 of your witness statement. Is there anything else that you would like to say?

A. Only that I think it's proven that if you take the inspection and the recommendation serious and the resources are put towards what can be achieved in a young offenders' institution, then clearly the outcomes for the children that are being cared for are better.

Q. Let's scroll in, in fact, on your report, please, at

your statement, please, HMP000405 internal page 3, paragraph 10, please -- 10 and 11, sorry, 10 and 11. You quote part of the report here and you say, I think, that this is the particular part that you think the panel might want to look at, that boys were positive about their early days at Werrington. Safeguarding and child protection arrangements were good. Support for boys at risk of self-harm was also good, although there was that concern about the use of violence. The outcome at the end of this paragraph:

"Outcomes of children and young people were reasonably good against this healthy prison test."

And that's the safety test, I think, isn't it?

A. That's correct.

Q. All right. You accept, I think, at paragraph 12 that efforts are required to reduce the level of violence in the establishment but that overall that was a positive inspection.

A. Yes, that is correct.

Q. Now, you've provided some observations in response to Mr Wood's evidence. Help us with what broad themes you want to draw out from the examination that he carried out. I think, obviously, he's looked at ten incidents over a 7-year period, so what's the broad point that you make about that?

A. Just the fact that is a very small sample size, I think. And particularly the issue around the complaint forms not being specifically for complaining or disclosing sexual abuse.
Q. Taking those in two parts, if I may. You make the point, I think, at paragraph 14 of your witness statement that seven years is a long time in the life of an establishment.
A. Yes.
Q. And I think the latest HMIP report that we have gone to you say is perhaps more helpful for the panel to look at in a broad sense. Is that right?
A. Yes, yes.
Q. But you note that he has observed that Werrington generally had responded in a timely and structurally appropriate way, which you welcome.
A. Yes.
Q. What's your view on the issue of the complaint forms that Mr Wood has raised, Mr Gormley? Help us with that.
A. I can completely understand Mr Wood's thoughts around the complaint procedure, but it is a generic complaint form for a number of reasons. It is, as I've pointed out in my statement, out of the ten sample size, only two of them, of the incidents, were actually reported by the complaints form, so it demonstrates to me that there

are a number of ways that a child can disclose information, not just using this complaints form.
I do have concerns that if we make a specific form for declaring abuse that may not be used, because I do think that some children don't understand what they're declaring.
I think the system that we've got at the moment with safeguarding trained staff who will look at a complaint and if there is an allegation of or a potential abuse element within that complaint then we process it well, because ultimately all those complaints then go to the safeguarding department where social workers and safeguarding staff will look at that complaint.
Q. So in fact you share the concerns expressed by the Feltham governor, is that right, that if there was a special box on the form for sexual abuse you would be concerned that that might miss some allegations because children might not know how to define it to put it in that box; is that one of the issues that you're talking about?
A. That is a potential, yes. Yes.
Q. And I think you say that you don't want the form to become too complex, you try and keep it as simple and straightforward as possible, because it's a generic form. You would be anxious to ensure that children

weren't discouraged by the form being structured in a certain, perhaps more complicated, way.
Help us, then, with what other routes are available at Werrington for the children to make disclosures if they wish.
A. So simply by talking to a member of staff, any member of staff. There are lots of independent people who work at Werrington. So, for example, there are youth workers, Kinetic Youth workers.
Q. That's Kinetic Youth workers, isn't it?
A. Kinetic, yes. There is advocacy service, which is Barnardo's. There is the independent monitoring board, then there is the social workers who are local authority social workers, so there is a whole range of staff they can talk to, or independent people.
Q. And you have CuSP officers I think already in place, is that right, at Werrington?
A. We do, yes. So that's like a personal officer to -- so the -- they will be identified for a number of children that they personally take, look after and meet with them once a week. They can certainly disclose anything to those members of staff and then there is the phone lines, ChildLine, the ...
Q. NSPCC line --
A. NSPCC, sorry, yes.

Q. -- and as with other institutions there is always availability of COMP 2, which is a confidential complaint to the governor. Is that right?
A. Yes, that's a standard form, the confidential complaints form.
Q. There's a chaplain, I think, as well?
A. Yes.
Q. And is this right: you've also explained that third parties who have observed changes in behaviour on the part of a child, or who have witnessed conduct which they consider to be inappropriate, or that's been reported by a family member could also come into the safeguarding route?
A. Yes, they can, the important thing for me is that whichever method of disclosure or potential disclosure takes place, it always goes to the safeguarding for a child protection referral where staff there, multi-disciplined staff will -- I call it triaging, where they would look at what the evidence or the submission states and then they'll take appropriate action.
Q. Dealing with the issue of the support that's given to children after disclosure of abuse is made, have you made the point, as others have, that perhaps Mr Wood has looked at the core documentation but there may be

evidence in other material of support being provided to the children?

A. Yes, so for example at Werrington, one of the main support mechanisms is that any child who makes an allegation will be seen by the embedded social workers. That social worker will stay with that child in terms of support until such time that the investigation or whatever the outcome is concluded.

Q. I think you go on, in fact, at paragraph 24 of your witness statement and say that in addition to the involvement of the dedicated social worker, every child making an allegation is seen by the duty governor and/or the orderly officer depending on the time of day you will conduct an initial assessment of the needs of the child, including any vulnerability that may arise from the making of the allegation and the need for immediate steps are to be taken, such as enhanced observations or a move to a different part of the establishment.

Have we understood that correctly, then, that what you're saying is that every child who discloses sexual abuse will be seen by the duty governor; is that what you are saying at 24 of your statement?

A. Yes, so if a serious allegation is made then the duty governor or the orderly officer, which is another one of the managers in the establishment, will go to see that

child because the overriding concern is obviously safeguarding and to see if there is anything that needs to be done immediately.

Q. Do you think there is any risk that that process, which involves the child being seen by a very senior figure in the prison, might make the child concerned about reprisals or might make it obvious that something serious has happened?

A. There is always a risk, of course, of that, but one thing that it demonstrates, I believe, to the child, is that it would take is seriously.

Q. I see, so you balance the two --

A. Yes.

Q. -- and you think in balance it's struck the other way?

A. Yes.

Q. The dialogue with the local authority that is now in place at Werrington, please help the panel with that topic.

A. So if an allegation is brought to the attention of the safeguarding department then, as I said, triage will take place through one of the social workers or maybe even both if they're available, a senior member of the management team and some of the safeguarding team, to decide what they will do with that allegation.

Clearly they will be in touch with the

local authority to have some dialogue to say whether they think it meets the threshold for a strategy meeting, section 47, and then they will task appropriate action from that dialogue.

Q. Is there anything else about the work with the local authority that you wish to draw to the panel's attention?

A. Yes, the local authority independently scrutinise incidents at Werrington. So, for example, under use of force, they will sit on a quarterly board meeting where they actually chair the meeting and they have access to view all incidents and/or paperwork and will review it and make recommendations to us about what we can do to improve, or if there are any concerns about a particular incident. They also do that for the child protection logs, as well, at the monthly safeguarding meeting.

Q. And what would happen if you had concerns about the LADO's assessment? So let's just say the LADO said that the case did not meet the threshold for a strategy meeting. What would happen then?

A. You mean if I have concerns that I thought it did?

Q. No, if you disagreed with the LADO's assessment.

A. Ultimately it's the LADO's decision but we will certainly have that conversation and, you know, they are quite challenging meetings where what I would call

professional tension is -- for me, actually, it's a necessity because that gives me the reassurance that actually staff are challenging and accepting -- not just accepting what, you know, one of the agencies say. They are multi-agencies so there are lots of opinion that make that decision -- lots of people, sorry, that make that decision.

Q. You say you have attempted to establish an environment which encourages a frank exchange of views between the professionals involved:

"It's not uncommon for there to be debate about the correct course of action, but as governor I find this to be reassuring, gives me confidence that we end up with the right course of action in each case."

Is that what you have said here?

A. Yes.

Q. As you know, one of the themes has been that Mr Wood has drawn out this concern about suspicion as opposed to validity. What do you wish to say about that, Mr Gormley?

A. I mean, the one incident that Mr Wood has pointed out is clearly that is an interpretation of that. What I would say in terms of reassurance is the fact that whatever the initial response is, the same process is followed in terms of the independent rigour that that is

investigated with and they are always done via a multi-disciplinary meeting, so whilst the words there, I can accept that that is the case on that one example.

Q. I think you say this: that there may well have been variability of practice in the observation in the period of time that Mr Wood was looking at. You're conscious of the need to keep staff aware of the importance of approaching complaints with an open mind and recording them in a neutral and objective way. And I think two further points you say you're not aware of any widespread deficiency in this regard at the moment, never flagged in the HMIP inspection and safeguarding department or the IMB haven't raised it either, so you're hopeful that that's not part of a wider problem now. Is that right?

A. That's correct, yes.

Q. The safeguarding department you say will consider every allegation in a rigorous and objective manner without any pre-judgment. Inevitably you do need to look at the complaints history of the child to some degree but you say:

"I assure the inquiry that the safeguarding department considers each allegation on its merits and without any pre-conception as to its validity."

Is that fair?

A. That's correct.

Q. And what is your response to the observations he has made about the concerns regarding aggression and violence on the part of the children appear to have framed the focus. What do you say about that?

A. The -- the one incident that was given, obviously it's concerning and staff should be able to respond in a manner which is appropriate to the child. Clearly, this one case I would have thought would have given rise for concern that if a child was responding in an aggressive manner more generally.

Q. I think you said that if staff are unduly distracted by the child's behaviour rather than subsequent complaint then that is a concern, but you have not had this wider concern brought to your attention by the safeguarding department or the local authority. Is that right?

A. That's correct.

Q. And in relation to the absence of records, help us with what you say about that. I think paragraph 36 of your witness statement, if it helps you, you say that I think you would accept that there clearly has been a record keeping failure in relation to some of the areas Mr Wood identifies. You go on to say you're not clear why in a particular case records have not been kept. You accept that they should have been and what do you say

about the position now?

A. Clearly records are -- have gone missing. That is a fault, as is the response in terms of the tone is a training issue. I believe that records are far more rigorous now. They are quality assured on a monthly basis and they are signed off by the governor of the establishment at the end of it, so I would say now we're in a much stronger position in terms of record keeping.

Q. How would you respond to the points he has made about the allegation in relation to gangs? So that was an allegation about sexual abuse in the context of gang membership and I think the suggestion was there appeared to be a lack of understanding of that context at Werrington. What do you say about that?

A. I don't think there is a lack of understanding of gangs. You know, we work with a lot of gang issues at Werrington, as well as all other establishments.

Q. I think you go on to say that gang membership may just be one of many reasons why a child might be reluctant to disclose.

A. Indeed, yes.

Q. And a difficult case involving rival gangs may well involve a range of strategies. We would hope that over time and with encouragement a child would be prepared to voice his concerns, but ultimately if a child is adamant

in his denial that he's been abused then you're simply unable to take the matter forward. Is that right?

A. That's correct, but the important thing for me is that we make sure we keep the door open for that child and at some point if they feel safe enough they will disclose something further.

Q. Having reflected as you have, Mr Gormley, on the issues that we have been through with you, is there anything else that you think Werrington can do to improve its systems to protect children from sexual abuse or to respond better when it happens?

A. Certainly in terms of resources, staffing resource, we now, as a youth custody service, attract and recruit specifically to members of staff who are going to work with children, which is important. The training element is also equally important. We do safeguarding initial training and follow-up safeguarding training and we are just introducing through reform and in part in response to the Taylor Report, we are introducing a youth justice foundation degree, which has elements of safeguarding in it and the good thing for that for me is that we are also in a position where we can refine and amend that delivery or that foundation degree, and our ambition is to have 100 per cent frontline staff trained in that.

So --

Q. Within the next how many years?
A. Well, it's a five year roll-out so it's 2023, I think. So it's an ambitious -- but it's something that we have started already. There are some 250 members of staff already signed up and --
Q. I think that's nationally, though, isn't it?
A. That's not Werrington, that's nationally, sorry, yes. So at Werrington there is, I think we got -- at last count there was about 34 on it, so we're getting to -- we've looked into using the word "professionalise", improve the standards and upskill the staff in terms of their knowledge about child -- and the way children respond, so that's really important for me.
Something that we have done at Werrington in terms of making things better was we have tried to make it a reward culture and not a punitive one, and that's taken a long time to change people's mindset, that actually if you reward children in terms of punishing them, outcomes generally tend to be a lot better.
Certainly having read the paperwork for this inquiry there is certainly, from my opinion, there is a need to improve on record keeping and responses, the way we respond to children.
Q. I think just in fairness to you, in relation to your point there about the incentive rather than punishment

culture, HMP000406, internal page 5, that was something specifically commended by the most recent inspection, was it not?
A. It was and it has made a big difference. It has made a big difference.
MS HILL: Thank you.
Chair, those are all my questions for Mr Gormley.
THE CHAIR: Thank you.
Ms Sharpling.
Questions by THE PANEL
MS SHARPLING: Thank you, just one question from me. Would you accept that -- we have heard a lot this afternoon about children and young people making or not making reports of sexual abuse. Would you accept that where violence is common or at unsafe levels in an institution that would actively discourage children from reporting sexual abuse?
A. I think it's linked. I'm not sure it's -- there's a direct cause and effect there, but I think it's definitely linked and for some children it probably would, yes.
MS SHARPLING: Thank you.
THE CHAIR: Malcolm.
PROFESSOR SIR MALCOLM EVANS: Thank you.
A short question, if I may, relating to -- I think

it's paragraph 37 of your statement, where you mention that if there is a complaint made against a member of staff a risk assessment is immediately undertaken on receipt of the allegation for the purposes of identifying the steps that may be required to separate the alleged victim and the alleged perpetrator. Who would undertake that assessment?
A. Well, that's part of the work who -- of the safeguarding department. However sometimes, you know, it needs to be done quicker than that, so it would be a duty governor or an orderly officer, who the report will be given to and they would have to do a dynamic risk assessment to say, you know, the overarching thing is to safeguard that child so if it's an allegation against a member of staff do we need to remove that member of staff from that unit, do we need to remove that member of staff from operations, so we put them what we call non-child contact, or do we have to actually suspend that member of staff, or if it's a child versus a child then what can we do with that child as the perceived victim and what do we need to do for that child as the perceived perpetrator.
So it's a dynamic risk assessment just to safeguard things until it can actually be investigated properly.
PROFESSOR SIR MALCOLM EVANS: Thank you very much.

THE CHAIR: Mr Frank.
MR FRANK: I think in fairness to you, in your witness statement, which is dated 13 July, so, what, last Friday, was it? You indicate that you have not yourself, you say, had an opportunity to investigate the alleged incidents that have been referred to by Mr Wood's report in detail. I think that's the way you put it.
A. That's right.
MR FRANK: But you're familiar with the contents of the report and the broad thrust of the incidents that he brought to our attention.
A. Yes, I am.
MR FRANK: You see, it may be right that you say that there were only ten alleged incidents over a period of five years and you say they may not be representative, but from the point of view of the child who makes the complaint, if they feel it has not been fairly investigated it's the only incident they need to know about to put them off making any further complaints in future if they have not been fairly dealt with.
So what I want to ask you is this: in respect of -- and we can put this up on the screen, please -- INQ001764_009, which refers to an incident on 24 February 2016, so not that long ago, we see there is

an incident where a written statement from the deputy governor who witnessed the alleged assault was not actually present on the file, it would appear. Can you help about that?

A. I can't, unfortunately, no. I have no knowledge of that.

MR FRANK: No evidence of a questioning of the deputy governor or of any other members who were present at the time of that assault; any idea about that?

A. I haven't.

MR FRANK: Do you think that's good practice?

A. No, it's not.

MR FRANK: Again, when we look at 1.47, in relation to there being no CCTV evidence, whereas the allegation took place in the child's cell where there would be no CCTV. Was that a proper reason for not furthering the investigation, the fact that there wasn't a CCTV record where you wouldn't expect one?

A. No.

MR FRANK: No and, again, if we look further down, 1.51, linked allegation, the fact that CCTV does not cover the young person's cell appears not to have been taken into account. Does that appear to you to be a proper response to that investigation?

A. No, it doesn't.

MR FRANK: No.

Yes, thank you, that's all I ask.

THE CHAIR: Thank you very much, Mr Gormley.

MS HILL: Thank you, Mr Gormley.

Chair, just in the remaining few minutes -- Mr Gormley can leave the witness box, thank you very much -- we have a short statement from Yvonne Gordon just to adduce this formally, please. Just by way of clarification, as I'm sure you've appreciated, chair, for each of the institutions there is a local authority that sits alongside that.

In relation to this particular local authority, Staffordshire County Council, Mr Wood confirmed in a report of 13 June at INQ001255 that there was no criticism of Staffordshire County Council in relation to their conduct on those allegations, so I will formally adduce, if I may please, just simply a statement from Yvonne Gordon that sets out the general systems in place as far as Staffordshire are concerned, and Werrington. That's a statement dated 16 February 2018, SFC000023 and the whole of that statement, chair, sets out their safeguarding processes in outline.

Chair, I wonder if I might just take the last few minutes just formally to adduce some material that we had hoped to read in last week that we didn't,

I'm afraid, have time to read in, because it is, perhaps, pertinent for you to be aware of this and have this in mind.

So, chair, we had hoped to read in some evidence from the independent monitoring board from Saffron Clackson in statements dated 20 May 2016 and Rachel Stuart, 3 July 2018, in IMB000001 and IMB000008, where they set out the role of the independent monitoring board in terms of visiting institutions and where they set out the number of complaints that had been made to that institution of sexual abuse.

Similarly, chair, we have also asked you to have regard, please, to evidence from the Prison and Probations Ombudsman. That's a statement, or a letter from Nigel Newcomen, dated 9 September 2016 at PPO000001 and information also from Elizabeth Moody, dated 10 April PPO000003, which again sets out the role they perform and the number of allegations they had had reported to them.

Finally in this group, please, there is a statement from the Children's Commissioner, Anne Longfield, dated 12 April 2018, INQ001175, and, again, confirming the role performed by the Children's Commissioner and confirming that they had received no disclosures of sexual abuse.

And then finally, please, we would ask you to have regard to material from Rosamund Roughton of NHS England, who has given a lengthy statement dated 28 November 2016, NHS000027, which sets out an overview of the role of the NHS as far as children in custody are concerned, includes information, for example, about the CHAT assessment tool, the comprehensive health assessment tool, about which you have heard, and includes further detail that we would ask you to consider.

And there is finally evidence from Nadine Good, assistant director at Barnardo's, dated 5 June 2018 in BRD000238, the pertinence, perhaps, of that material, chair, is that it goes to give you an understanding of the advocacy services Barnardo's provided, the information given to the children about those services. We have copied for you in the bundle that you have, chair, a range of exhibits that show the sort of material that children are given about the Barnardo's services, if you like, and also Barnardo's own policies.

There is also material exhibited to Ms Good's statement dealing with the number of allegations of sexual abuse that Barnardo's had received and that's in both BRD000238 and BRD000270. You may in particular wish to look at, as I have indicated, exhibit 2, which

is the material given to the children about that service and the statistics that are provided therein.

There is finally a very short statement dated 28 June at BRD000274, which brings up-to-date, I think, the prevalent information and provides further detail about the dates and hours of service of the advocacy services that are provided and some information about Barnardo's safeguarding referral processes, which you may remember have changed rather since the Medway Improvement Board's findings.

So, chair, I hope that brings us up-to-date with the read material and that concludes the evidence for today.

THE CHAIR: Thank you very much, Ms Hill.

(4.00 pm)

(The hearing adjourned until 10.00 am on Tuesday, 17 July 2018)

I N D E X