

<p>1 Monday, 16 July 2018</p> <p>2 (10.30 am)</p> <p>3 Welcome and opening remarks by THE CHAIR</p> <p>4 THE CHAIR: Good morning, everyone. I am Alexis Jay and</p> <p>5 I am the chair of the Independent Inquiry into Child</p> <p>6 Sexual Abuse and sitting this week with the other panel</p> <p>7 members of the Inquiry: Ivor Frank, Professor Sir</p> <p>8 Malcolm Evans and Drusilla Sharpling.</p> <p>9 Welcome to the sixth of the first substantive</p> <p>10 hearing of Children in Custodial Institutions</p> <p>11 investigation. Today the Inquiry will hear from some of</p> <p>12 the institutions, local authorities and further evidence</p> <p>13 from the investigations expert witness.</p> <p>14 Ms Hill, if there are no matters to deal with prior</p> <p>15 to hearing the witnesses, I will now invite you, as</p> <p>16 counsel to the inquiry, to call the first witness.</p> <p>17 MS HILL: Thank you, chair. There is just a couple of</p> <p>18 matters by way of housekeeping if I may. Chair, you and</p> <p>19 the core participants have been made aware of the</p> <p>20 witnesses we propose to hear from today and tomorrow.</p> <p>21 You will see that we have quite a lot of evidence to get</p> <p>22 through, so I am grateful, chair, for your indication</p> <p>23 that you are willing to sit until 4.30 today, but no</p> <p>24 later.</p> <p>25 As far as tomorrow is concerned, I think the CPs</p> <p style="text-align: center;">Page 1</p>	<p>1 I have just mentioned, he describes over the first few</p> <p>2 paragraphs the responsibilities of the Chief Inspector</p> <p>3 in respect of child custody, so I don't need to ask you</p> <p>4 about the detail of that, but could you just give</p> <p>5 a brief overview, please, of the responsibilities?</p> <p>6 A. So Her Majesty's Inspectorate of Prisons has</p> <p>7 a responsibility to inspect the treatment of prisoners,</p> <p>8 including children and the conditions and facilities</p> <p>9 that are available to them, broadly speaking. Our remit</p> <p>10 with regards to children is only in two of the three</p> <p>11 sectors that currently exist. We have no role in secure</p> <p>12 children's home inspections.</p> <p>13 Q. Turning, first then, to the issue of safety generally,</p> <p>14 please. Could we have a look at the annual reports at</p> <p>15 2016 to 2017 published on 18 July 2017 which is at</p> <p>16 INQ001442, if that could be pulled up on the screen,</p> <p>17 please, and within that, page 9. Could you zoom in on</p> <p>18 the bottom half of the page, please? I'd just like to</p> <p>19 read out a couple of sections of this and then ask you</p> <p>20 a question about it.</p> <p>21 The inspector here describes the custodial estate</p> <p>22 for children and young people and noted that the outcome</p> <p>23 of the inspections had been very troubling. In early</p> <p>24 2017 he, "felt compelled to bring to the attention of</p> <p>25 ministers my serious concerns about our findings", he</p> <p style="text-align: center;">Page 3</p>
<p>1 have been made aware that we propose to sit at 10.00 am</p> <p>2 and conclude at 4.00 pm in order to get through the</p> <p>3 evidence. I have circulated a very broad timetable for</p> <p>4 today, chair, that I believe you and the core</p> <p>5 participants have that we will endeavour to stick to as</p> <p>6 best we can.</p> <p>7 Mr Straw will question the first witness.</p> <p>8 MR STRAW: I'd like to call Mr Mulready-Jones.</p> <p>9 MR ANGUS MULREADY-JONES (affirmed)</p> <p>10 Examination by MR STRAW</p> <p>11 MR STRAW: Mr Mulready-Jones, could you describe your</p> <p>12 current role, please?</p> <p>13 A. My role is as lead inspector for children in detention</p> <p>14 for Her Majesty's Inspectorate of Prisons, so I am</p> <p>15 responsible for leading on policy, I lead many of the</p> <p>16 inspections of YOIs holding children and I contribute or</p> <p>17 I lead our contribution to the multi-agency inspections</p> <p>18 of Secure Training Centres.</p> <p>19 Q. Chair, with your permission, I'd like to adduce two</p> <p>20 witness statements produced by Mr Mulready-Jones, which</p> <p>21 are HIP000018 and 21 and then a statement by the</p> <p>22 Chief Inspector himself, Peter Clarke, which is</p> <p>23 HIP000012 and the Deputy Chief inspector Martin Lomas</p> <p>24 HIP000017.</p> <p>25 Mr Mulready-Jones, in Peter Clarke's statement which</p> <p style="text-align: center;">Page 2</p>	<p>1 says:</p> <p>2 "By February of this year, we had reached the</p> <p>3 conclusion that there was not a single establishment</p> <p>4 that we inspected in England and Wales in which it was</p> <p>5 safe to hold children and young people. The background</p> <p>6 to this dire situation is significant."</p> <p>7 Then he goes on to read out a number of statistics.</p> <p>8 A new annual report has been produced more recently</p> <p>9 than that, just on 11 July last year. Could you please</p> <p>10 describe how the situation has changed, if at all, since</p> <p>11 then?</p> <p>12 A. The situation is better. The situation in early 2017,</p> <p>13 there was a point in time that none of the institutions</p> <p>14 were judged "reasonably good" or "good" on our healthy</p> <p>15 prison test of safety or the Ofsted test of behaviour</p> <p>16 and safety in the Secure Training Centre framework. The</p> <p>17 judgments are slightly different in that framework, so</p> <p>18 it will be none of those institutions would have been</p> <p>19 "good" or "outstanding".</p> <p>20 Since that time, there has been some improvement in</p> <p>21 this area and we have seen several of the institutions</p> <p>22 be awarded our grade of "reasonably" -- "reasonably</p> <p>23 good". However, this has been to reflect some of the</p> <p>24 activity that's gone on in terms of behaviour management</p> <p>25 more broadly and not specifically their response to</p> <p style="text-align: center;">Page 4</p>

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

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

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1 described earlier?
 2 **A. Okay, so over the previous few years, the children's**
 3 **custodial estate has transformed in a number of respects**
 4 **so the first respect is, as I'm sure that other**
 5 **witnesses have told you, the number of children held has**
 6 **gone down by somewhere between 60 and 70 per cent. That**
 7 **has led to a number of institutions closing. That --**
 8 **that closure programme was -- led to children being held**
 9 **further away from home and the mix of children in**
 10 **custody has changed, as well, so the success of**
 11 **diversion schemes in the community both from the**
 12 **criminal justice system totally and within the criminal**
 13 **justice system from disposals that would lead to**
 14 **a custodial sentence to non-custodial options has led to**
 15 **a higher proportion of children in custody that are --**
 16 **that have previously committed a violent or sexual**
 17 **offence in terms of proportion, although I'm not sure**
 18 **that's true of overall numbers, because if you go from**
 19 **3,000 to 900 as the denominator, then the numerator on**
 20 **top also probably goes down as well.**
 21 **So the children are more likely to be in prison for**
 22 **a serious crime. We have also had some instability of**
 23 **management in some institutions, particularly in the STC**
 24 **sector, where we have had lots of changes of provider,**
 25 **either from the private sector back into HMPPS or**

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

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

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

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

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

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<p>1 until, you know, this will be ongoing, certainly at some 2 sites. There is something about terms and conditions, 3 but I think some work has gone into that. What I would 4 say is that there are now entry level salaries that are 5 comparable to other professions, and I think, if we are 6 paying professional salaries, we should be expecting 7 professional qualifications. 8 Q. I will come back to qualifications a bit later, if 9 I may, but first wanted to cover the issues of 10 privatisation. We have heard serious concerns being 11 raised about Medway and Rainsbrook when they were in G4S 12 control. Is this a fair summary of the other two 13 institutions which G4S continues to control: Parc, the 14 most recent survey and inspection judged its safety as 15 "reasonably good", whereas Oakhill STC, which is G4S's 16 second and final current child institution, is doing 17 poorly in terms of safety and, indeed, concerns were 18 raised with the ministers, is that correct, by the 19 inspector, because of how poorly it was doing? 20 A. Yes, we raised a -- we raised concerns at the last 21 inspection. We have just been to Oakhill recently so 22 not that inspection, the inspection before, regarding 23 levels of violence and a general lack of control of the 24 institution. 25 In terms of, I think was there a broader question</p> <p style="text-align: center;">Page 13</p>	<p>1 the top there, which include these. The first one: 2 "There is a concern due to the self-reporting nature 3 of the current STC contracts with a significant reliance 4 on contracts to provide data without a robust 5 independent assurance mechanism. Under-reporting of 6 incidents and issues therefore cannot be successfully 7 detected or challenged. The assessment of contracts 8 tends to focus on processes and not necessarily the 9 quality of the service delivered." 10 Then the final bullet point: 11 "There is a critical need for triangulating data 12 from different sources to form a holistic overarching 13 picture." 14 Do you have any recommendations as to how contracts 15 of private contractors can be better managed? 16 A. I think it's probably outside of the remit of the 17 Inspectorate to do so. What I would say is, when we 18 inspect an institution, we look for outcomes of the 19 people that are living there and what I have noticed, as 20 I go around inspecting institutions of all types, is 21 that often a lot of the things that are measured are 22 process. So there are lots of KPIs, but around process 23 rather than outcome, and we would do some of that 24 triangulating on inspection to come up with those 25 outcomes that are delivered. But in terms of</p> <p style="text-align: center;">Page 15</p>
<p>1 about privatisation? 2 Q. Yes, do you have a view whether private companies 3 running custodial institutions for children makes it 4 more difficult to care for them? 5 A. In terms of the evidence for inspection, there is no 6 evidence regarding the type of provider and the outcomes 7 we see. We see very poor outcomes in some public 8 provision, we see poor outcomes in some private 9 provision and, equally, we see some relatively good 10 provision in both sectors. 11 We don't see -- we see some very reactive managers 12 in some -- in some private sector institutions, we see 13 some poor managers. What I would say is, where we find 14 good outcomes, we often find good leadership at that 15 same institution and that's the thing that matters, 16 rather than the provider, and absolutely we have found 17 the sorts of poor practice that have been national news 18 at other institutions. 19 Q. A slightly different question which is about contract 20 management of private companies. Could we turn up, 21 please, HMP000187. This is something that was provided 22 by HMPPS. It comes up. It's an internal analysis of 23 Secure Training Centre contracts and can you turn, 24 please, to the third page of that. As you can see, it 25 was written on 21 March 2016 and four points are made at</p> <p style="text-align: center;">Page 14</p>	<p>1 recommendations, I'm not sure I could give you any clear 2 ones around contract management. 3 Q. Okay. The next issue, then, is CCTV. Could we turn up, 4 please, INQ001480. This is the 2017 report of Medway 5 and have a look, please, at page 10 of that. 6 Paragraph 29 it says: 7 "The centre still lacks CCTV coverage in areas where 8 young people have consistently reported feeling unsafe, 9 such as stairwells and education block. However, 10 inspectors were assured that CCTV coverage is shortly to 11 be extended across the centre and included in the 12 improvement plan." 13 First question, do you consider CCTV as important 14 for safety? 15 A. I think it is important but I don't think it's the most 16 important thing. I don't think that we can monitor 17 these places safe. The focus is on staff and 18 relationships, absolutely and that will be -- if I was 19 going to give one message, I think that that's the 20 issue. 21 The process is important and the fact that children 22 feel unsafe in those areas is important and needs to be 23 addressed, which is why it's referenced in that report, 24 so it has a part to play but it's not the whole picture. 25 Q. So far as you're aware, does CCTV currently cover all</p> <p style="text-align: center;">Page 16</p>

<p>1 public areas in youth custodial institutions that you 2 inspect or are there still gaps? 3 A. There will definitely be gaps across the estate, yes. 4 I couldn't tell you how many gaps sat here now, but 5 there will be gaps and there will also be gaps, in terms 6 of maintenance gaps, as well across the estate, of CCTV 7 cameras out of action at certain points. 8 Q. Page 25, please, at the bottom of the page, 9 paragraph 116 says: 10 "Some urgent remedial training ..." 11 This is still the report about Medway: 12 "Some urgent remedial training has been rolled out 13 across the staff group, including the safeguarding 14 module of the NOMS training course to ensure that 15 a minimum level of awareness is universal. This is 16 valuable training, but it is only a day in length and 17 cannot be regarded as enough to ensure that the 18 workforce is sufficiently aware of the safeguarding 19 issues. A range of appropriate further training is 20 planned and the volume of expression of interest from 21 the staff group is a good sign. However, the impact of 22 this training is some distance in the future." 23 Are you aware of what the current position is in 24 YOIs and STCs in terms of training; is this amount of 25 training referred to in this paragraph given in terms of</p> <p style="text-align: center;">Page 17</p>	<p>1 and information between those two, and I think that the 2 way they're recruited and retained is part of that 3 issue. 4 Q. What about training, leaving the initial qualification 5 to one side, do you think the mandatory training for 6 residential ordinary staff that they receive about 7 safeguarding at the moment is sufficient or should be 8 improved? 9 A. I think that the -- that if all of them get the 10 mandatory training, then the training is sufficient, but 11 you would need to talk about starting points of all 12 training, so if you had, in the same way that you would 13 talk about the outcome is, in terms of, rather than the 14 training programme, the outcome should be that all staff 15 have a current and good understanding of safeguarding 16 and how the process works. Some staff may come in with 17 that knowledge and other staff may not come in with that 18 knowledge, and what training each individual needs, in 19 the same way that you wouldn't expect two children, one 20 that's come in with GCSEs and the other with entry 21 level 3 qualifications, you wouldn't expect the same 22 provision to be provided for them children, you wouldn't 23 expect the same provision to be provided for staff 24 coming in. 25 Some people come in with degrees from the Prison</p> <p style="text-align: center;">Page 19</p>
<p>1 safeguarding or is more? 2 A. There is safeguarding training available for staff in 3 YOIs and STCs. I think the -- in terms of the equipping 4 staff for the role, I think there are two things in 5 terms of what qualifications and experience staff come 6 into the role with and what training is provided to 7 those staff once they get there, and I would -- again, 8 while it is important that staff have a current and 9 up-to-date knowledge of safeguarding, they will also 10 need other things as well to be able to work in this 11 sector appropriately. 12 Q. Focusing on ordinary staff, so residential staff that 13 have day-to-day contact with children, do you think 14 there should be a minimum qualification level for those 15 staff coming into working with children? 16 A. I think we should start to expect qualification levels 17 in terms of people coming into this environment in a way 18 that you would in other similar environments holding 19 children elsewhere, not just in the custodial sector and 20 that may well have two impacts, not just on the children 21 that are involved here, but on the expertise that you 22 would then draw on, because, at the minute, we seem to 23 have two children's workforces in the criminal justice 24 system. We have a community workforce and a custodial 25 workforce and there is very little sharing of expertise</p> <p style="text-align: center;">Page 18</p>	<p>1 Service College, some staff don't and I think we need to 2 have a more nuanced approach to this. So I think that 3 the approach requires improvement to take account of 4 that. 5 Q. Next paragraph, please, on the same page, you go on to 6 discuss, 117, supervision in Medway: 7 "There is no expectation that unit staff and 8 managers will engage in a supervisory relationship." 9 One sentence later: 10 "Supervision is an important tool to promote good 11 quality childcare practice in other residential 12 provision for under 18s, such as secure and open 13 children's homes. It is difficult to see how custodial 14 officers will be helped to continually improve their 15 performance and maintain a child-centred focus without 16 this, given that most staff have no childcare- or youth 17 work-related qualifications. It is also currently 18 unclear how poor performance by staff is dealt with." 19 Looking at YOIs and STCs generally, do you have 20 similar concerns; do you think that supervision in those 21 establishments is sufficient or it needs to be improved? 22 A. I think we have similar concerns across the estate. 23 There are particular issues around supervisory 24 relationships, so how many direct reports some staff 25 have, particularly in the public sector where custodial</p> <p style="text-align: center;">Page 20</p>

5 (Pages 17 to 20)

<p>1 managers in some institutions have a large number of 2 direct reports that cannot be supervised in a way that 3 you or I would be supervised in our job roles, in terms 4 of touching base with your manager every so often, and 5 it simply wouldn't be possible with some of these 6 residential managers. The reason that is, is that the 7 supervisory officer that sits between the custodial 8 manager and the band 3 officer has no line management 9 responsibility. 10 Q. A slightly different question about staffing. In 11 Mr Lomas' statement at paragraph 20, he indicates that, 12 in his view, the role of residential staff should be 13 primarily one of care. Do you agree with that? 14 A. Yes, I think that that underpins any model of 15 safeguarding that the staff should know the people that 16 they're looking after. They should have some regard for 17 those people and there should be a relationship of trust 18 that develops, so that if -- that prevents any type of 19 abuse happening in the first place, but if it does, it 20 means that children are confident that if they tell 21 their unit officer, who they spend most of their time 22 with, that that's what -- they have confidence that 23 something will be done about it and, while that 24 something is being done about it, they're protected from 25 further harm by that very same officer.</p> <p style="text-align: center;">Page 21</p>	<p>1 restraint process, which at paragraph 5.68 noted that, 2 for children who have been victims of abuse in the past, 3 restraint can be a highly traumatic experience. 4 Updating the position to now, do you consider that 5 the MMR process has been successful or can more be done 6 to reduce the incidence of unnecessary restraints? 7 A. I think, well, yes, more can be done to reduce the 8 incidence of unnecessary restraint, but, focusing on the 9 system of restraint, again, in the same way, is a little 10 bit of a red herring here. The -- it's the behaviour 11 management that reduces the need for restraint in 12 many -- in children's institutions, the overwhelming 13 majority of restraints are in response to violent 14 incidents or incidents of self-harm, and what you need 15 to achieve in terms -- in order to minimise unnecessary 16 restraint, is to have staff that are able and capable to 17 defuse situations before they get to the point where 18 restraint needs to be used and that's how you minimise 19 the restraint. 20 Then you can get into a discussion about whether 21 this technique or that technique is suitable, but, 22 actually, the bigger and more meaningful discussion is 23 about what happens before restraint when you're managing 24 a dispute on a residential unit. 25 Q. Strip or full searching so removing the clothes of</p> <p style="text-align: center;">Page 23</p>
<p>1 Q. And that primary role of care, is that currently the 2 case in YOIs or STCs or should changes be made? 3 A. I think there should be changes made to focus on that, 4 but that's not to say there are not officers that see 5 that as their role, that's not to say that there aren't 6 managers that see that as an aspiration. I think there 7 are structural difficulties, one of them being the high 8 number of -- the high amount of churn we have seen 9 recently in the workforce in these institutions and the 10 other is the very difficult environment. It's easy for 11 me to sit here in this room and say that prison officers 12 and their private sector equivalents should be caring 13 for children, but actually, if you come on to shift and 14 you're -- and you are having to challenge some very 15 difficult behaviour straight from the start, all week, 16 I think you would need some support and some real 17 guidance to explain what care means in that setting and 18 I think that that's missing and that's where the 19 management of those staff and that supervisory 20 relationship comes in. 21 Q. Moving on to the use of force and restraint on children. 22 The Chief Inspector of Prisons produced a report 23 in November 2015 which is at INQ001441 -- we don't need 24 to turn this up -- reviewing the early implementation of 25 the MMR, the minimising the management and physical</p> <p style="text-align: center;">Page 22</p>	<p>1 a child and then searching him or her, we understand 2 that there is a process whereby a form should be 3 completed which describes the reason for the search and 4 that the appropriate authorisation has been achieved for 5 it. Firstly, is there evidence that those forms are 6 always properly completed or in some cases are those not 7 properly completed? 8 A. In some cases they will not be properly completed. 9 Again, I couldn't give you a magnitude at this time. 10 Q. Just a couple of references. I have noted that in 11 a recent Medway report in 2018 at paragraph 10 and also 12 in the Rainsbrook 2016 report, which is INQ001571, at 13 paragraph 94, there was some comments that the forms 14 weren't being completed properly. 15 A second question about strip searching: we heard 16 that it was hoped that if there were safeguarding 17 concerns about the child -- for example, had been abused 18 in the past -- then those would come in through the 19 ASSETPlus assessment and would be filtered into the 20 decision as to whether strip searching would occur in 21 an individual case. 22 Do you have any comments on whether that aspiration 23 works in practice? 24 A. I think that that is an aspiration that in many of these 25 institutions is unrealistic. I think that the -- that</p> <p style="text-align: center;">Page 24</p>

<p>1 that information will filter into the institution, but, 2 in their current format, those searches will be 3 authorised on a fairly dynamic basis. So it's not -- 4 people don't meet up in a room before the decision is 5 made to authorise a strip search; it's often at the end 6 of a restraint. It's often because there is 7 an intelligence around a weapon or some other 8 unauthorised article and that -- then the risk 9 assessment is done and authorised on that basis.</p> <p>10 I think if you think of an institution -- just 11 picking one like Cookham Wood, where you've got 160 or 12 170 children, many of whom would have had prior 13 experience of abuse, for that individual member of staff 14 to know that individual child at that point, when they 15 have got hold of them in many respects and to -- and to 16 write that down and note that or consider that in a risk 17 assessment I think is a difficult position to put in.</p> <p>18 There are other searches that are authorised where 19 you would expect that to be completed and that all to 20 fit, but I don't -- I'm not sure if that is, as I say, 21 a -- in the current form of these institutions, I'm not 22 sure how you would always guarantee that that would 23 happen.</p> <p>24 Q. Thank you. Moving on to the question of whether there 25 are barriers to disclosure of sexual abuse, so factors</p> <p style="text-align: center;">Page 25</p>	<p>1 A. Yes.</p> <p>2 Q. In 2017, overall in STCs, are these the figures: no one, 3 21 per cent; staff on the unit, 41 per cent; family, 4 43 per cent.</p> <p>5 Just pausing there, were family the individuals who 6 children were most likely to want to turn to if they had 7 a problem?</p> <p>8 A. In 2016/17, family is the most -- yes.</p> <p>9 Q. Okay, with staff second?</p> <p>10 A. Yes.</p> <p>11 Q. Then you list a number of others, teachers, key worker, 12 case worker and, at the bottom, advocates, is that 13 right, at 9 per cent?</p> <p>14 A. Yes.</p> <p>15 Q. The remainder of the position about -- you ask a number 16 of questions there, for example, "Are complaints dealt 17 with fairly?", which is over the page, 54 per cent of 18 respondents said yes. Over the page again: 19 "Have you ever felt unsafe here?" 20 22 per cent of respondents said yes. And then over 21 the page, 8.10: 22 "If you were being bullied or picked on would you 23 tell a member of staff?" 24 61 per cent.</p> <p>25 A. Yes.</p> <p style="text-align: center;">Page 27</p>
<p>1 that might discourage a child from disclosing abuse, 2 Mr Lomas says at paragraph 12 of his statement: 3 "In order for children to have confidence in 4 reporting something as significant as sexual abuse, they 5 need to have confidence that staff will take their 6 allegations seriously."</p> <p>7 I would like you to help the panel, please, with 8 just looking through the recent statistics as to whether 9 children do have confidence in that.</p> <p>10 Could we turn up, please, INQ001200. 11 The computers seem to have stopped working. 12 The file is not in there, okay. 1200. Can we try 13 the number again just in case, it's INQ001200. 14 No, okay. We will try and resolve that and come 15 back to that issue later.</p> <p>16 A. If it's helpful, I have the data in front of me.</p> <p>17 Q. You do? Excellent. That will help. In that case 18 I will go through with you, then. This is the 19 appendices to the Children in Custody, 2016 to 2017, 20 report, so the most recent one. Could we have a look, 21 please -- it's not sequentially page numbered, but could 22 we have a look at appendix A2, so, "Survey responses 23 from children and young people in STCs". Do you ask the 24 question, in STCs: 25 "If you had a problem, who would you turn to?"</p> <p style="text-align: center;">Page 26</p>	<p>1 Q. Because of the time, I will just skip over to the 2 picture in the YOIs before asking you the question, 3 please. In YOIs, I'd like to look at the survey 4 responses by YOI and overall, please. There, to 5 respondents in YOIs, you ask a slightly different 6 question. You ask: 7 "Can you speak to a chaplain of your faith in 8 private, a peer mentor, a member of the IMB or 9 an advocate?"</p> <p>10 Just pausing there, is there a reason why that 11 question in STCs which lists a number of different staff 12 is asked for STCs but not in YOIs?</p> <p>13 A. Yes, although not a particularly good one. The two 14 surveys were designed at different times and for 15 different settings -- at the current moment, we will 16 have a new survey combining both settings. We will be 17 able to compare the responses from children in STCs and 18 children in YOIs. Also, when we became involved in 19 STCs, their population was significantly -- I mean, it 20 is still significantly different but less so than those 21 held in YOIs and so we took out a lot of the detail, so 22 while that's -- there is more detail in that question, 23 as a whole, the survey is much shorter and simpler in 24 STCs than it is in YOIs.</p> <p>25 The combined survey that we're currently doing will</p> <p style="text-align: center;">Page 28</p>

<p>1 be somewhere in between the two.</p> <p>2 Q. Okay, but you're reviewing and rationalising?</p> <p>3 A. Basically, yes.</p> <p>4 Q. Okay, so moving on:</p> <p>5 "If you had a problem, would you have no one to turn</p> <p>6 to?"</p> <p>7 23 per cent said yes. Then you go on:</p> <p>8 "Do you feel complaints are sorted out fairly?"</p> <p>9 26 per cent said yes:</p> <p>10 "Do you feel complaints are sorted out quickly?"</p> <p>11 Only 21 per cent said yes:</p> <p>12 "Have you ever felt unsafe here?"</p> <p>13 39 per cent said yes. Then over at 9.10:</p> <p>14 "If you were victimised, would you tell a member of</p> <p>15 staff?"</p> <p>16 28 per cent said yes:</p> <p>17 "Do you think staff would take it seriously if you</p> <p>18 told them you had been victimised?"</p> <p>19 Only 27 per cent said yes.</p> <p>20 Can you help broadly in that, why is the picture in</p> <p>21 YOIs so bad?</p> <p>22 A. The picture in YOIs is so bad for those reasons that</p> <p>23 I have told you earlier on. I mean, these are</p> <p>24 institutions where they -- there are -- well, until very</p> <p>25 recently, there has been an inconsistent staffing</p> <p style="text-align: center;">Page 29</p>	<p>1 survey. The system works differently in STCs. The --</p> <p>2 you know, people get on their emergency cell bell for</p> <p>3 a number of different reasons, but, you know, often</p> <p>4 they're asking for things like toilet rolls or minor</p> <p>5 things. It's an emergency cell bell; they're not really</p> <p>6 meant to be asking for toilet rolls when they're</p> <p>7 pressing it. But, as I say, if you're living in</p> <p>8 an institution that cannot guarantee those basics of</p> <p>9 everyday life, I'm not sure you would have the</p> <p>10 confidence to do something.</p> <p>11 If I say that you have assaulted me in a YOI, I'm</p> <p>12 putting myself at risk and someone else has to protect</p> <p>13 me. And I need to trust that they're going to protect</p> <p>14 me and they're going to be able to keep you away from</p> <p>15 me.</p> <p>16 Q. Mr Lomas, in his witness statement at paragraph 14,</p> <p>17 indicates family or friends -- positive relationships</p> <p>18 with family or friends is a protective factor.</p> <p>19 Over the page in your survey, you ask some questions</p> <p>20 about family and friends, 12.1:</p> <p>21 "Are you able to use the telephone every day?", and</p> <p>22 68 per cent of respondents said yes.</p> <p>23 12.3:</p> <p>24 "Do you usually have one or more visits per week</p> <p>25 with family and friends?"</p> <p style="text-align: center;">Page 31</p>
<p>1 picture. There has been an inconsistent regime in many</p> <p>2 of these institutions, so you don't know what is</p> <p>3 happening from day to day, and the approach to behaviour</p> <p>4 management hasn't been sophisticated enough to</p> <p>5 incentivise people to behave. So when children come</p> <p>6 out, they're coming out to fairly chaotic environments</p> <p>7 where -- I mean, I don't want -- the violence is</p> <p>8 an everyday feature. It's unusual in an YOI to not have</p> <p>9 an alarm bell going at that day or on a particular day,</p> <p>10 requiring a staff response.</p> <p>11 Now, if you see all of that going on, the</p> <p>12 institution is meant to prevent all of that happening to</p> <p>13 you, it's meant to prevent -- it's meant to ensure that</p> <p>14 you get up at a time, that you go to school at a time,</p> <p>15 that you have your lunch at a time, that you are out of</p> <p>16 your cell consistently for this amount of time and that</p> <p>17 you don't experience violence.</p> <p>18 Now, if you see, every day, those things happening,</p> <p>19 you're not going to trust the institution to respond</p> <p>20 very well to your problem, when you see it. If you see</p> <p>21 that the institution is responsible for stopping this</p> <p>22 stuff and can't stop this stuff, then you are going to</p> <p>23 have a lack of faith when you raise the issue yourself.</p> <p>24 The other thing to say is you will also notice there</p> <p>25 is a question about cell bell response times in the YOI</p> <p style="text-align: center;">Page 30</p>	<p>1 And only 34 per cent of respondents in YOIs said</p> <p>2 yes.</p> <p>3 12.4:</p> <p>4 "Is it easy, or very easy, for your family and</p> <p>5 friends to visit you here?"</p> <p>6 And, again, only 32 per cent of children said yes.</p> <p>7 In terms of telephones, are telephones always in</p> <p>8 private or in some YOIs are they in positions where</p> <p>9 they -- the child may be overheard when talking to their</p> <p>10 family and friends?</p> <p>11 A. Yes, sorry, to answer the question, they're not always</p> <p>12 in private in YOIs and they are sometimes in places that</p> <p>13 they could be overheard. It just depends on how close</p> <p>14 people are standing to you whilst you're on the</p> <p>15 telephone.</p> <p>16 Q. In the Feltham report in 2017, INQ001205, you -- I think</p> <p>17 the inspector notes that the telephones are held in</p> <p>18 corridors; is that right? So there may be children</p> <p>19 walking past or members of staff as they're talking to</p> <p>20 their family. And is it also correct that telephone</p> <p>21 calls with family are not necessarily confidential, so</p> <p>22 a member of staff might be listening --</p> <p>23 A. Yes.</p> <p>24 Q. -- to that? And visits also, is it right family visits</p> <p>25 tend to be in a big hall so not confidential?</p> <p style="text-align: center;">Page 32</p>

<p>1 A. Mm-hmm. 2 Q. And may -- or if a child wants to write a letter to 3 their family, again, it may be read by a member of 4 staff? 5 A. Just to put some context on that figure of 32 per cent 6 family visits, or approximately 32 per cent find it 7 easy, you have to put this into context. Many of these 8 children have come in with prior care experience, and so 9 there will be very good reasons why their family find it 10 very difficult to visit them while they're in custody 11 and, if you look at the annex, you will find 12 a looked-after children comparator and you will see 13 a real stark difference between those questions on 14 family between those people who have a prior care 15 experience and those people that were, for want of 16 a better word, living at home before they came into 17 custody. 18 Q. And Mr Lomas in his statement makes a recommendation 19 that children should be held closer to the communities 20 in which they live to facilitate those relationships? 21 A. Yes. 22 Q. And a similar one, custodial institutions holding 23 children should be smaller to facilitate positive 24 relationships between staff and children. 25 A. Yes.</p> <p style="text-align: center;">Page 33</p>	<p>1 from their perspective, that makes little difference to 2 them, whether it's a -- the establishment is much 3 larger. 4 Q. Whistleblowing, Mr Lomas says at paragraph 15 there is 5 evidence to suggest that staff in custodial institutions 6 holding children rarely blow the whistle on poor 7 practice and abuse carried out by colleagues. 8 Is that your understanding of the position? 9 A. Yes, I think we do see examples where staff do blow the 10 whistle on poor practice, but we -- they are -- they're 11 not as many as you would like. Again, I don't think 12 this is a problem limited to the custodial estate. 13 I think we have seen similar in -- across all 14 professions, I think people are reluctant -- in the same 15 way as we ask that question, "Would you tell a member of 16 staff?" or "Would you think your complaint would be 17 taken seriously?" , I would suggest that many people 18 working for a range of different settings would say, 19 "I'm not quite sure I trust that whistleblowing hotline 20 or the ability of this institution to protect me if 21 I put my head above the parapet". 22 Q. Okay, I'm sorry, we're rather rushing through all the 23 issues because we have very limited time. So I will 24 move on to the response. In the Medway -- in one of the 25 Medway reports, which is, let me just get the year, the</p> <p style="text-align: center;">Page 35</p>
<p>1 Q. What do you think -- do you support that? 2 A. Yes. I think the two things are linked, so you hold -- 3 well, we hold 900 children in custody, give or take, and 4 we did a thematic inspection on the impact of distance 5 from home and we found that you received -- broadly 6 speaking, one view is that for every 25 miles you were 7 held further from home, and that was visits by both 8 family members and professionals, so in terms of that 9 external relationship and your ability to maintain it 10 and your ability to have contact if you did want to make 11 a complaint or tell someone that something had happened 12 to you, the distance absolutely matters and if you 13 simply do the -- the maths on how you construct 14 an estate with 900 children in it, you would have to 15 have those -- to enable them -- people to be held 16 anywhere near where they're coming from, you would need 17 to have a greater number of smaller institutions. 18 The smaller institutions is more about smaller 19 living units and personal relationships on those units, 20 so in theory, you could have a very large institution 21 that was broken up into lots of small living units, that 22 sort of mimics a smaller unit, but that's a point that 23 we're driving at there in terms of the size. It's 24 a size from the perspective of the child, so if they are 25 living on a smaller part of an establishment, I suppose,</p> <p style="text-align: center;">Page 34</p>	<p>1 2016 report, there were concerns -- and the reference is 2 INQ001479, but no need to turn it up -- and concerns 3 were raised that child protection matters were not 4 managed effectively and young people were not 5 sufficiently safeguarded and it drew attention to 6 a number of specific concerns about the responses to 7 child protection referrals. 8 Is that only Medway or are there concerns in some 9 other places? 10 A. There are concerns in some other places at different 11 points in time, so that's a relatively dated assessment 12 of Medway, as we stand today. I think there have been 13 two subsequent inspections of Medway and I think their 14 safeguarding has been assessed as marginally improved 15 from that report. 16 However, those sorts -- I think that report says 17 that there were five delayed referrals and one of which 18 the local authority didn't have a record of. 19 The one about the local authority not having 20 a report of is unusual. We rarely find that. We do 21 find delays, so the general problem with referrals to 22 local authorities is the timeliness, making sure all of 23 the information goes with the referral and, to be frank, 24 then chasing up the local authority to make sure that 25 the local authority is investigating in a timely</p> <p style="text-align: center;">Page 36</p>

<p>1 fashion. But that's not an unusual -- those sort of 2 five that were out of time, and all there were delays 3 with, it's not unusual for us to find that in other 4 institutions.</p> <p>5 Q. Moving on to the inspector's powers, in the 2018 annual 6 report, which is HIP000022 at page 63, it records, so 7 far as safety is concerned, 34 per cent of previous 8 recommendations were achieved, 15 per cent partially 9 achieved but more than half, 51 per cent, were not 10 achieved.</p> <p>11 Has a similar picture been in place over the last 12 few years?</p> <p>13 A. I think there has been a decline in the system. Those 14 figures are a response to all inspections across all 15 sectors. The -- there has been a decline in the number 16 of recommendations that have been achieved from the 17 previous inspection in general, so it's been getting 18 worse.</p> <p>19 Q. Okay. And at INQ001580 there was a press release from 20 Peter Clarke, the Chief Inspector of Prisons, dated 21 16 February 2018, in which he was discussing concerns 22 about Liverpool Prison, an adult prison, and the 23 Justice Select Committee's response to it, but in that 24 context, he made this comment, that he would welcome the 25 Select Committee's recommendation that independent</p> <p style="text-align: center;">Page 37</p>	<p>1 February 2016. There is a guide for inspectors as well 2 from January 2018, a safeguarding policy. The 3 references are HIP00008, then 9, 10 and 11. Does the 4 inspection regime apply equally to STCs and YOIs?</p> <p>5 A. The inspection regime?</p> <p>6 Q. Yes.</p> <p>7 A. The inspection regime is different in all three sectors, 8 so the STC inspection regime happens annually, as does 9 the YOI inspection, but the frameworks are different, so 10 the YOI inspection framework has four tests: safety; 11 respect; purposeful activity; and resettlement. The STC 12 inspection regime has more tests which include safety, 13 behaviour management, care, healthcare, resettlement 14 achievement, leadership and management and overall 15 effectiveness, so there are significant differences in 16 the structure of the report. In reality, we looked at 17 very, very similar things, particularly in regard to 18 safety, but the make-up of teams is different. While we 19 have Ofsted, CQC and ourselves on both inspections, we 20 lead in YOIs, Ofsted lead in STCs, Ofsted have the bulk 21 of the inspection team in STCs, whereas the reverse is 22 true in YOIs, and the -- as I say, we don't -- some of 23 those tests you will notice are completely absent from 24 YOIs while they're involved in the other one, and we 25 certainly don't have that overarching judgment in the</p> <p style="text-align: center;">Page 39</p>
<p>1 scrutiny needs to be injected into monitoring the 2 implementation of inspection reports, and he said: 3 "It is crucial that progress in implementing HMP 4 recommendations is transparent and independently 5 verifiable. The abject failure of too many prisons to 6 take inspection reports seriously must stop." 7 Do you support a sort of mechanism of that form 8 where there is some form of independent scrutiny of 9 recommendations?</p> <p>10 A. Yes, absolutely. We regularly find that the 11 institution's own assessment of where they are and how 12 many recommendations they have achieved is optimistic 13 and of a different order to what we -- they make the 14 assessment of when we follow up those recommendations. 15 So it would make sense that if we are making these 16 recommendations, then, in those establishments that are 17 struggling, that we -- there is some mechanism where we 18 would be able to go and check that those recommendations 19 are being implemented appropriately, both in terms of 20 making sure that the establishment understands the 21 purpose of that recommendation but also in some -- you 22 know, as well as sort of from a sort of audity 23 perspective, as well.</p> <p>24 Q. The inspection regime, we have a number of documents on 25 the system, including the HMIP inspection framework from</p> <p style="text-align: center;">Page 38</p>	<p>1 YOI sector.</p> <p>2 So in regards to frequency, yes, it's the same, but 3 in terms of what that looks like on the ground, there 4 are real differences.</p> <p>5 Q. Mr Lomas, at paragraph 26, said: 6 "There should be one inspection regime for the 7 sector, YOIs, STCs and SCHs, that continues to give 8 significant weight to safeguarding and child 9 protection." 10 Would you support that?</p> <p>11 A. Yes, I don't think there is any good reason why we 12 inspect these three sectors differently.</p> <p>13 Q. The Chief Inspector has also said in public that, in 14 fact, in his most recent annual report that the 15 inspection regime ought to be -- have a statutory 16 footing. Do you support that and, if so, why is that 17 important?</p> <p>18 A. Yes, I do support that. I think there was a Prisons and 19 Courts Bill that got lost in the mists of time that 20 would have assisted HMIP and put some of our powers on 21 a more formal footing. Some of that has happened 22 already in terms of the urgent notification process and 23 there is -- there are developments happening in terms of 24 following up from inspections, as well. 25 But putting the organisation and inspection on</p> <p style="text-align: center;">Page 40</p>

<p>1 a statutory footing, while our actions are independent 2 as we are now, in reality the organisation is an arm's 3 length body of the Ministry of Justice and we have -- 4 and the organisation itself still is not referred to in 5 any sort of legislation. We are just a Chief Inspector. 6 Q. Should there be a greater investigation during the 7 HMIP's inspections of safeguarding issues? I have two 8 suggestions here, but please do tell me if these are 9 already part of your inspections. 10 So, for example, analysing the proportion of staff 11 which have received mandatory safeguarding training or 12 to test staff's understanding of key areas in respect of 13 safeguarding. Do you think what's asked at the moment 14 or what is inspected at the moment is sufficient or more 15 can be done? 16 A. We ask as part of inspection of our inspection 17 methodology for training figures for a large range of 18 things, including safeguarding training and inspectors, 19 I would expect them to be, as they were going round -- 20 particularly residential staff -- to be asking how they 21 would make referrals in terms of safeguarding. 22 A point, though, about safeguarding and our 23 framework, there is a section called "Safeguarding and 24 child protection", but there are also sections around 25 suicide and self-harm prevention, violence reduction and</p> <p style="text-align: center;">Page 41</p>	<p>1 the survey findings alone. We then triangulate that 2 with evidence we have collected during inspection. 3 What the survey does do is give an accurate picture 4 of the perceptions of a very large number of children 5 that are detained at a point in time, so we have about 6 a return rate about 84, 85 per cent, which is very, very 7 high and we have been doing this for a number of years, 8 so you can monitor sort of trends and things getting 9 better or worse, but the survey is absolutely not 10 designed to get an accurate picture of child sexual 11 abuse in custody over a period of time. It can only do 12 what it's designed to do, which is to take the 13 perceptions of the children at the time that the survey 14 is conducted. 15 Q. Howe & Co who represent a number of core participants 16 have put forward a question or suggestion of statutory 17 agency, perhaps similar so the US Bureau of Justice 18 statistics whose role is to collect, monitor and perhaps 19 audit allegations of sexual abuse. So to carry out 20 a wider and more detailed survey. Do you have any 21 comments on that? 22 A. I think that there is nothing wrong with having 23 a statutory agency with responsibility for making sure 24 that these statistics are accurate and that they are all 25 reported. I see the recommendations, such as</p> <p style="text-align: center;">Page 43</p>
<p>1 so on, which are obviously also safeguarding too. 2 Q. Surveys. In the witness statement by 3 Peter Clarke, May 2016, he noted that since 4 1 January 2002 until the date of his witness statement, 5 so it's a slightly different period to what the inquiry 6 has been looking at, HMIP had records of 221 reports of 7 alleged sexual abuse against a child in a custodial 8 institution. Now, have you heard that the inquiry has 9 asked all relevant bodies to produce information about 10 allegations that they had received and in the period 11 between 1 January 2009 and 31 December 2017, a slightly 12 different period, there were 1,070 allegations as 13 a whole. 14 Do you have any comment on that? Is the 15 Inspectorate supposed to be there to get a complete 16 picture of abuse or is it just a snapshot at the time of 17 the surveys? 18 A. We are there to inspect, as I said before, the treatment 19 of prisoners and the conditions in which they were held. 20 Now, that is much wider than the prevention of abuse, so 21 the survey itself is designed as a tool to inform 22 inspection. So what the survey does is gives inspectors 23 looking at that area -- whether it be victimisation, in 24 this case -- whether it looks like there is a particular 25 issue at this institution. What we never do is rely on</p> <p style="text-align: center;">Page 42</p>	<p>1 HMI Prisons to collect the data. I think, if there was 2 a duty, that would have to come with resource. 3 A point about the methodology in the United States 4 is that their survey methodology is a sample survey, the 5 it's not -- they don't survey, as we do, every single 6 child. They survey roughly about 15 per cent of the 7 children and they don't do it as frequently as we do. 8 They rely, also, on report data from the institution and 9 from the institutions in terms of allegations of abuse 10 which is probably a very similar route to some of those 11 other route -- allegations that make up your total 12 number that you've described. 13 I think it makes sense for them to be together in 14 one place, but I think I would be cautious of saying, 15 "This seems to look good over here and so we would 16 implement it there". I think there are things that 17 probably are better, but there are some things that 18 maybe are not as robust as what is happening here at 19 this minute in time. 20 Q. I think you have seen the Howe & Co proposals for 21 reform. Another question they have asked is whether you 22 support a child safeguarding authority. Do you have any 23 comments on that or any of the other proposals for 24 reform that Howe & Co have put forward? 25 A. I think the creation of a child custodial safeguarding</p> <p style="text-align: center;">Page 44</p>

<p>1 authority, while I can see the sentiment behind that, 2 I think there are risks involved, what the Inspectorate 3 would like to see is a competent safeguarding authority 4 that applied the same thresholds to children in custody 5 as children in the community and ensure that they were 6 protected. 7 I think in the current system we have local 8 authorities with that duty and some of them, obviously, 9 are – some of them operate more effectively than others 10 and that, I suppose, is a danger, but one of the risks 11 of having a child custodial safeguarding authority is 12 that that becomes separate from children in other 13 settings in a way that, when I talk about workforce, 14 it's perhaps not as – you know, it has risks as well as 15 benefits. So you could – you know, you could look at 16 that one organisation and say, "Well, we will make sure 17 that this operates well", but actually the risk is it 18 becomes a slightly siloed service from other 19 safeguarding agencies. 20 And the other thing that I think, again, to go back 21 to my original point, which is around that I'm not sure 22 that process and structure is the whole story here 23 about, you know, changing this structure or that 24 structure in terms of external oversight. I think that 25 there is something about the fundamentals of how the</p> <p style="text-align: center;">Page 45</p>	<p>1 institutions is an illusion of oversight because lots of 2 people are looking at something quite briefly, so there 3 are links of oversight to a local authority LADO who may 4 or may not have experience specifically of what the 5 issues are in custody. There are obviously some 6 oversight arrangements through local partnerships or 7 Safeguarding Boards, but, actually, they are stretched, 8 and their ability to dedicate resource to this. Then we 9 have ourselves who are coming in once a year. And then 10 you have the management line, which, while it has been 11 rationalised some way in terms of the children's – 12 children in custody sector – in terms of children in 13 custody we still have three agencies at the centre that 14 have some oversight of this space in terms of the 15 management, some policy input from the YJB and some 16 policy – some oversight from the YJB and the policy 17 team in NOMS. 18 So, yes, I think that that could be rationalised 19 and, if it was, or at least some of those processes were 20 aligned, managers could ensure or could focus more of 21 their time on improving outcomes in their institutions 22 rather than oversight and governance. 23 Q. The last issue is just going back to the inquiry's 24 prevalence analysis. In 2016, the inquiry's prevalence 25 analysis found 32 allegations of sexual abuse in Medway.</p> <p style="text-align: center;">Page 47</p>
<p>1 day-to-day stuff operates in these institutions that 2 safeguard children. 3 In terms of one other recommendation that is made 4 around a recommendation that we have previously made 5 around Feltham, obviously what we would like to see is 6 that all of our recommendations are implemented by 7 HMPPS. I don't know whether you wanted me to comment on 8 any of the other things in this document? 9 Q. I am very tight for time, so I'd better on move on, but 10 thank you. I just have two final questions, then, two 11 final issues. The first one is about regulation, 12 oversight and governance. I think in Mr Lomas' 13 statement he notes at paragraph 16 that external 14 regulation, oversight and governance arrangements are 15 complex and lead to institutions being held to account 16 by several external agencies for different aspects of 17 their work. 18 At 25, he recommends they should be rationalised. 19 Do you support those concerns? 20 A. Yes, I think what we find is managers doing several 21 things for several different masters, ourselves and the 22 inspection regime being one of them, and I think one of 23 the dangers of recommending solutions is that it's 24 always easy to recommend another process for managers to 25 implement and I think that what we have in some of these</p> <p style="text-align: center;">Page 46</p>	<p>1 As I understand it, in the 2016 survey of Medway, which 2 is INQ001479_001, it was noted that at the time of the 3 survey there were 36 people in Medway -- 36 children in 4 Medway and 33 questionnaires were responded to. None of 5 them said that they had been sexually abused on the 6 survey and, similarly, the next snapshot, 7 28 February 2017, which is the next survey, the 8 population of Medway was 29 children and, again, none of 9 them said that they had been sexually abused. 10 Can you help us understand what's happening there as 11 to why it may be that the -- there was a zero per cent 12 response rate to the snapshot survey that you took but 13 a number of allegations appear to have been made 14 elsewhere? 15 A. I think that people respond differently to different 16 methods of reporting child sexual abuse. I think that 17 that -- and actually you need several different 18 safeguards operating at the same time, so I imagine that 19 what you have got there is people have reported to the 20 institution or staff have reported separately in terms 21 or there may possibly be historical allegations that 22 involve people that have left the institution. I don't 23 know what the nature of those allegations are. I would 24 suggest that some of that is a churn of the population 25 but in reality there will be -- there's no perfect</p> <p style="text-align: center;">Page 48</p>

1 **methodology in making sure that everyone reports all of**
 2 **the time every time they're asked.**
 3 Q. Thank you. Chair, with your permission, I'll just
 4 adduce formally a few other documents that I haven't
 5 mentioned yet. One of those is INQ001457, a report
 6 about Rainsbrook and then INQ001569, another such report
 7 and, finally, chair, just to draw your attention to two
 8 of the witness statements, which describe the number of
 9 different establishments to which HMIP had received
 10 allegations of sexual abuse from and then the statement
 11 by Mr Mulready-Jones dated February 2018, he actually
 12 gives details of a number of the allegations that have
 13 been made, so quotes there, quotes from the children
 14 themselves who have left comments on the surveys.
 15 Does the panel have any questions?
 16 Questions by THE PANEL
 17 THE CHAIR: Thank you, I have one, Mr Mulready-Jones.
 18 You have referred quite frequently to the
 19 relationship between the quality of leadership and
 20 better outcomes, so do you think that the quality of
 21 leadership across the estate is good enough to address
 22 the many and complex issues that we have been hearing
 23 about?
 24 **A. I think we would have to say no because we have assessed**
 25 **the leadership and management to be not good enough in**

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1 **some of the institutions, with -- in the STC estate and**
 2 **demonstrably it's not good enough yet to deal with some**
 3 **of the issues that are in the YOI estate. There has**
 4 **been a lot of change over the recent time and have been**
 5 **some improvements, which is why I've given a sort of**
 6 **mealy-mouthed outcome, but to answer the question**
 7 **directly, I don't think currently we could say yes to**
 8 **that question.**
 9 THE CHAIR: Thank you. Ms Sharpling?
 10 MS SHARPLING: Thank you, Mr Mulready-Jones. Just
 11 a question of clarification for me, I'm not sure whether
 12 you said it or not, that's why I am asking. Can you
 13 tell me the underlying reasons why the framework for
 14 YOIs are different from STCs?
 15 **A. They are designed by two different organisations, so**
 16 **while the STC framework is a joint framework with**
 17 **ourselves and the CQC and Ofsted, the lead inspectorate**
 18 **is Ofsted and so their policy team draft the framework**
 19 **and they commend and so on. It's not -- and also it's**
 20 **a hangover from a system that was larger in parts and so**
 21 **it made a lot more sense when there were more children**
 22 **in custody. It was hidden that we had sort of these**
 23 **different approaches in different sectors, but actually,**
 24 **when you get down to it now and you've only got about**
 25 **600 in YOIs and another 120, 130, 140 in STCs, it does**

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1 **seem odd that you would inspect those outcomes there in**
 2 **different ways and, again, a third way different in**
 3 **secure children's homes. So I think -- and it hides**
 4 **some comparability of outcomes across sectors.**
 5 MS SHARPLING: Which brings me on to my next question: is it
 6 possible to fix that?
 7 **A. The legislation appoints the inspectorates but it is**
 8 **possible, it would be possible to fix it, yes, it's not**
 9 **beyond -- with inspectorates drafting new legislation --**
 10 **new frameworks that changed the current frameworks and**
 11 **I think given the reform in the sector, I think that**
 12 **that will be necessary when we have a fourth model of**
 13 **custody, but at the minute, I think the frameworks --**
 14 **the inspection regime reflects a rather fragmented**
 15 **sector rather than a sort of taking a more strategic**
 16 **approach across all three types of custody.**
 17 MS SHARPLING: I see, thank you.
 18 THE CHAIR: Sir Malcolm?
 19 PROFESSOR SIR MALCOLM EVANS: Thank you, just one very small
 20 question: I couldn't help but notice that when we were
 21 looking at paragraph 117 of the 2017 inspection report
 22 on Medway a little while back, it mentioned that one of
 23 the difficulties was that whilst minutes were saying
 24 that individual staff would be spoken to or receive
 25 letters about their conduct, "as no staff files are

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1 maintained, it is not possible to see whether there is
 2 any follow through here".
 3 **A. That was -- without having the report to my -- to hand,**
 4 **I think that was a particular problem with Medway at**
 5 **that inspection at that time. There was an issue about**
 6 **records across the site, not just records of the staff**
 7 **and what's happened with the staff, but records of the**
 8 **children and what's happened with the children in terms**
 9 **of their ongoing care.**
 10 PROFESSOR SIR MALCOLM EVANS: So that would be specific to
 11 Medway at that time --
 12 **A. At that time.**
 13 PROFESSOR SIR MALCOLM EVANS: -- rather than generic
 14 practice?
 15 **A. Yes.**
 16 THE CHAIR: Thank you very much. We have no further --
 17 MR STEIN: Chair, sorry to interrupt and I don't want to
 18 delay progress of the day. We note that
 19 Mr Mulready-Jones has read the Howe & Co recommendations
 20 and proposals. He hasn't, I don't think, had the time
 21 today to go through those and provide his own opinion.
 22 What we would ask, if he's prepared to, and as long
 23 as counsel to the inquiry has no objection, would be if
 24 he could provide an answer to those proposals in
 25 correspondence?

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1 THE CHAIR: Are you willing to do this?
 2 **A. Yes.**
 3 MR STEIN: We're very grateful.
 4 MR STRAW: Mr Mulready-Jones, would you be willing to
 5 produce something in writing in response to those
 6 questions?
 7 **A. Yes.**
 8 MR STRAW: Perhaps we can deal with it that way.
 9 MR STEIN: Thank you.
 10 THE CHAIR: Thank you very much. We will now take a break
 11 and return at 5 past noon.
 12 (11.48 am)
 13 (A short break)
 14 (12.05 pm)
 15 MR ALAN WOOD (recalled)
 16 Examination by MS HILL
 17 MS HILL: Thank you, chair.
 18 Mr Wood, you're already under oath. Thank you very
 19 much for returning to give some further evidence. Just
 20 to orientate, you, Mr Wood, and the rest of the
 21 participants in the proceedings, I had hoped to ask you
 22 some very brief questions about some of the generic
 23 themes you had elicited from some the case studies
 24 material, but it may be that we should just press on to
 25 deal with the Feltham matters.

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

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1 in the material that you saw?
 2 **A. That's right, yes.**
 3 Q. Over the page, 8.1.2, one theme was an apparent
 4 perception by members of staff about the young people
 5 and that seemed to frame how they responded to the
 6 allegations?
 7 **A. That's right.**
 8 Q. 8.1.3, you've made observations about how well
 9 understood the previous trauma and abuse of the children
 10 was by the staff?
 11 **A. That's right.**
 12 Q. 8.1.4, you raised questions about how well staff were
 13 trained and supported in dealing with those issues?
 14 **A. That's correct.**
 15 Q. 8.1.5, again, a question about the role of the child
 16 having had a previous experience of authority and what
 17 that meant in terms of engaging with the complaint and
 18 investigative processes?
 19 **A. That's right.**
 20 Q. 8.1.6 was a broad theme about perhaps process rather
 21 than content?
 22 **A. That's right.**
 23 Q. 8.1.7 was a sense that some of the staff seemed to
 24 regard the children as "other" and that that perhaps
 25 formed their response to the children's allegations?

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

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<p>1 A. That's right. 2 Q. All right, thank you. Can I try and drill down a little 3 bit now, please, then, to some of the institutional 4 issues that arose around the Feltham analysis that you 5 did and can I begin, please, by orientating the panel by 6 bringing up, please, INQ001228_002, which, Mr Wood, is 7 just the letter of instruction you were sent in relation 8 to Feltham, and perhaps just scroll in on that list of 9 incidents underneath the heading "A", because that shows 10 the panel the number of incidents and the broad date of 11 the incidents that you were invited to look at. 12 A. That's right, yes. 13 Q. So the panel can see here that you were asked to look at 14 15 different allegations from Feltham. They range 15 from October 2008 and I think you were asked, 16 ultimately, to not look at that one because it's before 17 our 2009 start date but you then focused on a series of 18 allegations from September 2009 through 19 to September 2015. 20 A. That's correct. 21 Q. Just putting that document to one side, and I won't 22 bring these documents up, but just to give the panel 23 a broad flavour of it, the underlying material that you 24 were asked to look at -- the panel won't see this in 25 your report, but I am just, hopefully, trying to give</p> <p style="text-align: center;">Page 57</p>	<p>1 health worker had sexually assaulted a child. Is that 2 right? 3 A. That's correct, yes. 4 Q. I think that was the 28 November 2012 incident and 5 that's HOU000003. 6 Turning then, if I may, to the themes that you 7 elicited, can I look up, please, your second and third 8 report. It's INQ001210 and it's internal page 8. You 9 dealt with your views on Feltham under three headings. 10 Firstly, you applied the general principles of good 11 practice to Feltham. Then you dealt with some more 12 points of detail around allegations against members of 13 staff. In fact, forgive me, it's two headings in 14 relation to Feltham. 15 Is this right, Mr Wood: that as far as the initial 16 recording of an allegation is concerned and the initial 17 response, we can perhaps scroll in on 3.1.1 on this 18 page, you felt there was a wide variation in terms of 19 the approach and standard in terms of the recordings. 20 And I think the two themes you brought out later around 21 this were that the record seemed to reflect a lack of 22 understanding about the complication caused by the child 23 being in custody, about them being scared to report. 24 Just tell us a little bit more about that, would you? 25 A. That's right, yes. I think one of the major themes to</p> <p style="text-align: center;">Page 59</p>
<p>1 a bit of detail here -- is that, for example, the 2 allegation from 9 September 2009 was an allegation by 3 a young person, a 17-year old who submitted a complaint 4 in which this was written: he had been searched by 5 a female prison officer: 6 "She sexually assaulted me by squeezing my penis 7 a couple of times. I have several witnesses who saw the 8 assault." 9 We don't need to bring that up but that's HOU000003 10 internal page 29. And several of the other incidents 11 that you were asked to look at had arisen because 12 a child had disclosed the allegation in one of the 13 survey responses? 14 A. That's right. 15 Q. Some of the other allegations, just by way of example, 16 that you were asked to look at involved one suggestion, 17 I think this is 19 March 2012. An incident that you 18 were asked to look at involved an officer coming into 19 the cell to hand out lunch. The child was wearing boxer 20 shorts. The officer, it was said, had grabbed the child 21 by the genitals. That's the sort of thing you were 22 looking at? 23 A. That's right, yes. 24 Q. And then just one, I think, perhaps final example. 25 There was one example of a suggestion that a mental</p> <p style="text-align: center;">Page 58</p>	<p>1 me was the fact that -- mentioned last time, some of the 2 child's responses to custody in terms of externalising 3 behaviours may elicit a response from members of staff 4 in terms of trying to restrain them, so these are -- 5 there is a gap there in terms of understanding the 6 connection between those two things: previous 7 experiences; and the current behaviour. 8 In terms of the form actually to record any 9 allegations against staff, Feltham did stand out in lots 10 of ways in terms of the inconsistent approach, so we 11 have mentioned before, I think, that, actually, a large 12 range of forms are available to use and routes in to 13 making an allegation against a member of staff. There 14 was inconsistency in terms of the method, inconsistency 15 in terms of the written response. One of the themes 16 which did stand out was that there was consistency in 17 terms of records in terms of members of staff, so one of 18 the concerns I had was that there were clear pathways in 19 terms of -- from an HR perspective, in terms of members 20 of staff, those weren't replicated from a child or young 21 person's experience. 22 There seems to me a lack of impetus to examine the 23 whole picture, linked to the withdrawal or denial of 24 allegations being made, as well. And there was some 25 examples of that.</p> <p style="text-align: center;">Page 60</p>

<p>1 Now, I think using different methods to collate 2 information, written by different people at different 3 times, the tracking of those things in terms of being 4 able to learn or to improve from those examples was 5 absent, as well, so it was quite hard actually to track 6 what had actually happened across the range of 7 documents. 8 Q. So I think you're suggesting that the documentation 9 suggested a better insight into the impact and 10 allegation on the staff member than the child. Is that 11 right? 12 A. That's right, yes. 13 Q. And that there was a perhaps inconsistent approach to 14 the support given to the child or, indeed, no apparent 15 support from the documentation being given to the child. 16 Is that right? 17 A. That's right. I think one of the things for me, as 18 I mentioned several times in several reports I've done, 19 that based on information I've actually seen, that's the 20 picture. That information may be recorded elsewhere, 21 but there was no cross-referencing to those other 22 records which may exist from Children's Service 23 departments from the police records, so it's very hard 24 to see how those things actually joined up. 25 I could only comment on the records I have seen, so</p> <p style="text-align: center;">Page 61</p>	<p>1 Q. I think another broad issue that you brought out was 2 that there was, on occasion, a need for the child to 3 report the allegation to more than one person to sort of 4 repeat it and I think you felt that this was a rather 5 difficult process. Can I ask you, please, to bring up 6 your fifth report and, in particular, what you say about 7 this at 1.15 and 16, so it's INQ001764 and it's internal 8 page 4. 9 If you scroll in, please, on 1.15 and 16. You seem 10 to be concerned across several of the institutions, but 11 including Feltham, about the number of members of staff 12 who became aware of allegations and this overexposure, 13 you call it of the allegations. Is that something you 14 can comment a little bit further on, please? 15 A. I think -- I think elsewhere in the report, and other 16 reports, I mention the fact that just by the very nature 17 of a custodial institution, it is actually quite hard to 18 keep things completely confidential due to the fact of 19 handovers of staff, risk assessments are being completed 20 all the time on children and young people, so I think, 21 in terms of when a child discloses sexual abuse, it is 22 hard to keep that contained. The risks around that are 23 that members of staff who may or may not be involved may 24 become aware of those allegations. Other children and 25 young people may become aware because the child may talk</p> <p style="text-align: center;">Page 63</p>
<p>1 I did mention several points. It may be elsewhere, but 2 it's not actually explicit. 3 Q. Just to be clear, that is a point that's been raised in 4 several of the institutional responses, that there may 5 be evidence of support elsewhere. I think what you're 6 saying is that on the core documents you were sent, on 7 the child protection logs and things of that nature, it 8 wasn't obvious what that support was? 9 A. That's right. I think, from my perspective, it would 10 have been really helpful if a log of other potential 11 evidence sources which are linked in terms of the major 12 records are examined, so it's about multi-agency 13 approaches, as well. So no one agency is responsible in 14 its entirety for safeguarding children; all agencies are 15 responsible. I think it is hard, though, when agencies 16 don't actually tie in to other records, so this may be 17 available elsewhere. It would be quite helpful to see 18 written down, but it wasn't written down anywhere. 19 Q. Would that sort of joined-up approach be consistent with 20 the Working Together approach? 21 A. It is completely consistent with this. I think the 22 additional complexities of custody add a different 23 aspect to that as well. However, all agencies are 24 responsible for safeguarding children and young people, 25 so it needs to be reflected across all agencies.</p> <p style="text-align: center;">Page 62</p>	<p>1 to other children and young people around those 2 confidential issues, as well, so it is very difficult 3 to -- to actually to work through that. 4 I think in terms of an absence of a record of that, 5 it would be helpful, I think, for agencies to record the 6 difficulties they may have in keeping things 7 confidential, and then to put in some management around 8 that. But overall, it is actually quite hard to do 9 that. 10 There were some examples in terms of institutions, 11 talking about Feltham in particular, where children and 12 young people were concerned that other members of staff 13 may become aware of allegations, as well. 14 Q. Perhaps I can take you to an area where you deal with 15 that in your first consideration of these issues, 16 please, it's INQ001210_010 and scroll in, please, on 17 3.1.16 where I think you had raised a particular 18 observation about a child being concerned that their 19 complaint had not been kept confidential but seemed to 20 be known about by the partner of the member of staff who 21 was then treating the child differently. Is that 22 a summary of one example? 23 A. That's correct, yes. I think there, again, the added 24 complication is that the member of staff who those 25 allegations were made against may well have spoken to</p> <p style="text-align: center;">Page 64</p>

1 his or her partner about the allegation. Again, I think
 2 it would have been helpful to see a record from the
 3 child protection logs or some sort of record written
 4 down about this issue and say what they were going to do
 5 in terms of trying to deal with that risk factor.
 6 Certainly from the records I saw, the young person's
 7 perspective was that they were being treated in
 8 a different way, and the allegation had actually been
 9 made.
 10 Q. Thank you. You have already highlighted, I think, if
 11 you go to the top of that page, please, a theme of the
 12 disparity in the apparent understanding of the impact on
 13 staff compared to the impact on children. Is there
 14 anything more that you would like to say about that, how
 15 that reflected itself in the Feltham records?
 16 A. I think for me the -- one of the core issues for me is
 17 in terms of whose record it actually is. I think from
 18 a member of staff point of view, it is important
 19 obviously to record allegations or concerns or
 20 complaints and to log those and to follow a correct
 21 process associated with the contract they're actually
 22 having to work to.
 23 One of the concerns I suppose I had really was --
 24 it's quite clear, you can see the pathways whereby
 25 members of staff were invited to meetings. It's all

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1 written down in a clear way. The results of those
 2 meetings are very clearly written down. You could
 3 easily pick out what the processes were, what the issues
 4 were, what the next steps were and that wasn't always so
 5 obvious when the child actually made an issue, so there
 6 is two different ways of thinking about it.
 7 Now, it may be -- and I think agencies, I have
 8 already said in another response to the report, that
 9 those records, in terms of the response in terms of
 10 support for the child, may be lodged somewhere else,
 11 that may be the case, but there was no cross-referencing
 12 to the records I saw, so that's one issue I think in
 13 terms of evidence based work.
 14 The issue about restraints --
 15 Q. Let's come to that, if we scroll in, please, on 3.1.13.
 16 I think what you had mentioned here -- sorry, it's 12
 17 and 13, forgive me -- is that there was a concern here
 18 about the way in which a restraint issue had been dealt
 19 with. Tell us what your findings were there.
 20 A. I think for me, I mentioned several points, I suppose,
 21 that a child's pre-existing experience of trauma or
 22 abuse may configure their internal working view of the
 23 world, so they may be expecting conflict, aggression and
 24 I understand that workers are trained specifically to
 25 restrain in certain ways to cause the least amount of

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1 harm and with the most amount of care.
 2 I think, however -- I think in terms of how a child
 3 can actually perceive that loss of power, loss of
 4 control, it's quite clear that there's a number of
 5 allegations across the entire range I've looked at
 6 whereby restraint is a starting point, so children would
 7 perceive that restraint in a certain way. It's also
 8 aligned to searches, as well, so if children have made
 9 comments around that, as well. And the view was, this
 10 is a thorough search, this is a complete -- completely
 11 within the rules of restraint. However, the child's
 12 experience of that wasn't really recognised or picked
 13 out from that.
 14 Now, I do understand working in an environment
 15 whereby high levels of conflict and stress are around
 16 all the time. However, that child's individual
 17 experience of that episode should be reflected, I think,
 18 in terms of the records.
 19 Q. I think we have seen in the response by the
 20 Ministry of Justice and indeed some of the witness
 21 evidence that we will hear today that the allegations
 22 that you looked at, as we have seen, ended in 2015 but
 23 there is, now, a different process in place --
 24 A. There is, yes.
 25 Q. -- as far as restraint is concerned?

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1 A. Yes.
 2 Q. And our understanding is that there will be some debrief
 3 of the child after restraint?
 4 A. Yes, I was very pleased to see that.
 5 Q. What sort of thing would you hope to see that that
 6 debrief includes, Mr Wood?
 7 A. I think in terms of -- from a behavioural response,
 8 I suppose, in terms of what was leading up to the
 9 restraint, why the staff actually identify the need to
 10 restrain or put hands on a child, enabling the child to
 11 understand what the rules were and why restraint was
 12 important under some limited circumstances.
 13 I think for me it's aligned also to there would be
 14 a large amount of information which would be known about
 15 the child if they've got history of involvement prior to
 16 coming into custody. So all information about their
 17 past lives, experiences, their past trauma, their past
 18 child protection status, past involvement with social
 19 care or other agencies, all that should be known, so it
 20 may not come as a surprise to staff, then, if children
 21 respond in certain ways.
 22 So actually, it's about the staff and the agency
 23 taking responsibility to understand the child as much as
 24 possible what triggers may emerge from their past
 25 experiences and also enabling the child to understand

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<p>1 what the rules are and how the rules are different 2 within custody to outside of custody and what the 3 consequences of some of their behaviour might be. 4 So I think a debrief is in two elements. It's the 5 child's understanding and the member of staff's 6 understanding. I did see the response in terms of -- 7 from the recent attempts to improve practice in Feltham 8 in terms of creating a log to make sure that if certain 9 members of staff are more prone to restraining children 10 and others weren't that could be now identified, which 11 is very helpful, I think, in terms of understanding the 12 staff issue as well as the young person's issue, because 13 my experience would say that some members of staff are 14 more skilled and more able to deescalate prior to 15 restraint, others members of staff may move to restraint 16 in a quicker way, so you can understand that from 17 a debriefing as well. 18 Q. Just following on from that, one of the points that you 19 have made in your report, I think at 3.1.13, was that 20 where there was a concern that the restraint of a child 21 had not followed expected training you were suggesting 22 that there wasn't evidence of any follow-up with the 23 member of staff concerned? 24 A. That's right. 25 Q. But is it your understanding that that would now occur</p> <p style="text-align: center;">Page 69</p>	<p>1 made, reactions can be interpreted in a certain way 2 which may actually escalate the issue, the conflict 3 issue. 4 And I think understanding children's point of view 5 in terms of what relationships adults mean to them, past 6 experiences would be useful. I think from 7 a confidentiality point of view, that would be done in 8 a careful way because you wouldn't want to expose the 9 entire history of a child across the entire range of 10 adults. 11 But with a key worker approach, they could hold 12 information. The members of staff can go to that key 13 worker and say, "Actually, I saw this today. Does this 14 make sense in terms of the past experiences?", and 15 a discussion could happen then. 16 I think in terms of the resource implication, and 17 it's the care and control relationship which we spoke 18 about last time, if you think about safeguarding is at 19 the heart of all activity with children and young 20 people, then workers have got a responsibility to make 21 sure their actions are understood and interpreted by 22 a child within that perspective. 23 Q. So I think, is this fair, that what you're saying is 24 that, albeit fully recognising that restraint may be 25 necessary on occasion?</p> <p style="text-align: center;">Page 71</p>
<p>1 as part of some formal debrief? 2 A. What I've recently read in terms of the papers presented 3 to me, I think the response now seems very robust now. 4 It's quite a recent change and I think also for me it 5 would be about understanding compliance, not only in 6 terms of the correct forms being filled out, but 7 understanding the child's experience of that, as well. 8 So inspection could bring that out. 9 Q. Just a final question on this topic, please, to what 10 extent would it be your expectation that that pool of 11 knowledge about a child would be available to the staff 12 member who has to make that decision in the moment about 13 whether to restrain that child? 14 A. I would think that, I mean, the essence of a care 15 planning process would be that key people would have to 16 know what the presenting issues were for the child. 17 I think that could be done in a way whereby the child 18 doesn't feel their entire past history is exposed to 19 a series of adults or members of staff whom they may 20 have very limited contact with. However, I think there 21 are key themes which could be drawn out from that, so my 22 view would be that the pre-existing knowledge which 23 agencies have about children in terms of experiences 24 should be used in a child centred way, in an appropriate 25 way, but it's essential, otherwise decisions can be</p> <p style="text-align: center;">Page 70</p>	<p>1 A. Yes. 2 Q. That in deciding whether to restrain a child, the fact, 3 if so exists, that that child has been already 4 physically or sexually abused should be part of that 5 decision-making framework? 6 A. I think -- I think, you know, sitting here, it's easy to 7 say that in terms of a -- 8 Q. I appreciate that. 9 A. -- detached view, I think, in terms of the harsh fact of 10 having to deal with the child's escalating behaviour in 11 front of you as an adult, and I've certainly been in 12 situations whereby that's happening. I think the skill 13 is understanding what's behind that behaviour and also 14 enabling the child to feel that is another option. It 15 does take some skill to do that and some support and 16 some supervision and some elements around that to do 17 that, but I think in terms of, if you don't want a child 18 to have a repeated experience of trauma and abuse, which 19 then adds to their sense of isolation and no control and 20 no power, then I would say that understanding where the 21 child's perception comes from is important. In 22 practical ways, it's difficult to do that. I think 23 staff would have to be trained to understand what may be 24 lying behind some of the behaviours. 25 Q. Or, indeed, even if the behaviour is entirely unrelated</p> <p style="text-align: center;">Page 72</p>

1 to past abuse --

2 **A. Yes.**

3 Q. -- the fact of restraint potentially retraumatising

4 a child. Is that right?

5 **A. My experience of seeing restraints happen, being**

6 **involved in some restraints as a member of staff is that**

7 **it can be a very traumatising experience for the child.**

8 **My approach would be to talk to the child throughout the**

9 **entire restraint, remain some contact. I think once the**

10 **emotions and the heightened emotions of restraint are**

11 **happening, it's very difficult for children to hear what**

12 **adults are saying to them. The damage can be done**

13 **between that period, so when the brains are effectively**

14 **switched off from what's gone on, and factually, it's**

15 **somebody responding from an emotional point of view, it's**

16 **a survival technique, it's very hard to communicate at**

17 **that point, but I think maintaining that drip, drip,**

18 **drip of positive contact is important in that restraint**

19 **and I think it is difficult, I think I've certainly been**

20 **involved, you know, seen events happen whereby the**

21 **behaviour escalates, restraint happens, the child gets**

22 **worn out, effectively gives up, is then moved to**

23 **somewhere that's a safe space and the same pattern**

24 **repeats itself over and over again and for some children**

25 **that's their way of communicating and understanding,**

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1 **having contact with adults, which is totally harmful in**

2 **the short and long-term. That's a factual thing.**

3 Q. It's a further complicating factor of it?

4 **A. Absolutely, yes.**

5 Q. Moving on from restraint issues, Mr Wood, if I may, can

6 I deal now with some points about the nuts and bolts, if

7 I can call it that, of how allegations were

8 investigated --

9 **A. Yes.**

10 Q. -- and pull up, please, 3.1.3, which is the same report

11 but at internal page 8, where you refer here to two

12 incidents where complaints forms have been completed,

13 had highlighted sexual abuse but where both of the

14 children denied completing the form. All right? So can

15 you comment on what you drew from that and how that was

16 dealt with?

17 **A. Again, from examination of the records which were there,**

18 **these two separate children made two separate**

19 **complaints, both denied filling them out and I think for**

20 **me, there is a lack of evidence, I suppose, in terms of**

21 **what was going to happen next, then, so the form was**

22 **filled out by someone and people -- I think the staff**

23 **member seemed satisfied with the explanation that it**

24 **wasn't me. Now, I suppose in terms of looking at the**

25 **range of options children would have and I know the**

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1 **Ministry of Justice has outlined a range of options in**

2 **terms of the pathways to making an allegation against**

3 **a member of staff or a child, the form is one of them,**

4 **and I suppose, for me, it would have been helpful to**

5 **understand a little more about whether this is**

6 **a surprise to staff, this came as a common factor.**

7 **To me, it was left in that stage whereby the child**

8 **was saying, "It wasn't me", and it is difficult. If**

9 **a child is denying an allegation, then there is an end**

10 **to that. You can't keep on trying to fish information.**

11 **There is an end to it, but I felt that it would have**

12 **been helpful to have a written explanation about what**

13 **happened next, if anything.**

14 Q. Because it could have been a retraction of

15 an allegation, couldn't it --

16 **A. Absolutely.**

17 Q. -- rather than a mistake?

18 **A. Absolutely right, yes. I think for me it would have**

19 **been helpful to show how these things were actually sort**

20 **of worked out. So making a decision to do nothing is**

21 **still making a choice, and that's what happens, I think.**

22 **So it would have been useful to show how the thought**

23 **patterns are worked out, why the end result was that**

24 **way, instead of just recording "Retraction allegation,**

25 **denial", that was the end.**

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1 Q. And I think is this fair, if you go on to 3.1.5 in your

2 report, you saw a similar pattern where complaints had

3 actually been withdrawn, so withdrawal of complaints

4 appear not to have been followed up in terms of

5 analysing and evidencing the meaning of the allegation

6 to the child, given the context of it being made and the

7 reasoning why it was later withdrawn?

8 **A. That's right.**

9 Q. That's a similar sort of theme, is it the?

10 **A. That's right.**

11 Q. While we're dealing with this, you do say at 3.1.4

12 a perhaps general observation that I think perhaps

13 permeates the YOI analysis about the use of complaint

14 forms and the practitioner point, I think, that you pull

15 out of this is that there is, as we heard from your

16 evidence last week a difference between concerns,

17 complaints and allegations that have a significance for

18 your practitioner head --

19 **A. That's right, yes.**

20 Q. -- if you like, that perhaps doesn't carry over to

21 a complaints form in custody. So please help us with

22 what you have drawn out under that topic.

23 **A. I think for me, it goes back to the Howe & Co**

24 **recommendation, I suppose -- I think it was**

25 **recommendation 9 -- in terms of having a way to manage**

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<p>1 or a way to record in a clearly transparent, trackable 2 way. And what I found really and what I experienced, 3 looking at the entirety of this and the record, it's 4 very difficult to track those things, understand what 5 actually happened, so -- and I think for me also, from 6 a complaints point of view, a complaint to me has 7 a different outcome, a complaint under stage 1, stage 2 8 and stage 3 could be investigated, it may be deemed not 9 to be substantiated at any point in stage 1 or stage 2 10 or stage 3, but I think for me the use of the word 11 "complaints" when we're talking about allegations of 12 sexual abuse, there is a gap there, to me.</p> <p>13 A complaint may be against a member of staff who 14 understands it would have to be recorded in a certain 15 way, but there were examples -- may not have been in 16 Feltham, but other institutions, I can't recall at the 17 moment, but there were definitely examples whereby 18 children actually spoke to a member of staff about 19 an allegation and then he told them to fill out 20 a complaints form.</p> <p>21 Well, to me, it's that adult's responsibility to 22 take forward that allegation and not -- it isn't very 23 helpful to say to a child, "Stop where you are, fill out 24 a complaints form", which may -- they may not be able to 25 do anyway, but also may be worried about writing things</p> <p style="text-align: center;">Page 77</p>	<p>1 what the results were, that's the fundamental keystone. 2 Q. Moving, then, to some issues you had raised about the 3 actual quality of the investigation when a disclosure 4 had been made, 3.1.14, please, it's internal page 10 of 5 that same document. I think there are several different 6 points you made under this heading, and at 3.1.14 you 7 pulled out that there had been two, I think historical 8 allegations of sexual abuse made by adults in regards to 9 staff at Feltham which had not been pursued. Tell us 10 what your concern was about the way those had been 11 investigated.</p> <p>12 A. One of them was really about -- one route was that they 13 advised some mental health professionals that it wasn't 14 the correct thing to do to follow up that allegation due 15 to the mental health state of the adult. I wasn't clear 16 from the record in terms of what explanation was around 17 that or what support could be put in for that for the 18 mental health issues, so there's a gap there.</p> <p>19 Now, it may be that's very standard advice and it 20 may be the correct advice, but it would have been really 21 helpful to understand how the institution responded to 22 that, to say, "Well, that's the case, what we're going 23 to do about this allegation".</p> <p>24 The issue, the other issue, was that there was 25 an issue in terms of a decision was made not to -- not</p> <p style="text-align: center;">Page 79</p>
<p>1 down and then -- it then goes somewhere else. 2 Q. Is that one of the examples of a sort of focus on 3 substance not form that -- forgive me, form not 4 substance, that you identified that there was quite 5 an adherence to process that you seem to have pulled out 6 as a key theme. Is that fair?</p> <p>7 A. That's fair, yes and I think for me it's the -- it's the 8 experience of the child is the most important thing, 9 it's actually quite hard to spot that. I mean, forms 10 can be filled out to whatever extent they're going to be 11 filled out to and you may gain information from those 12 forms, but I think in terms of the number of 13 substantiated allegations which ended up -- whichever 14 route was taken, was very low across all institutions 15 anyway, so the outcome for children was hard to spot, 16 I think.</p> <p>17 So I think for me, the procedures are complex 18 anyway. The inspection frameworks are complex and may 19 not actually complement each other across the entirety 20 of the span, so that's into the mix as we stand now and 21 for a child to try to navigate their way through that 22 actually is quite hard. So I think for me, there are 23 advantages and disadvantages, but I think, for me, to 24 have a system or a process whereby we can track exactly 25 how many allegations were made against whom and when and</p> <p style="text-align: center;">Page 78</p>	<p>1 to pursue one of the allegations of historical 2 background issue. I think for me, again, a rational 3 explanation about why that decision was made and to work 4 backwards from that was actually absent from the record. 5 I think it may say, sort of later on in the report why 6 that was.</p> <p>7 Q. Then I think a second theme that you pulled out from the 8 Feltham analysis was certain examples of records being 9 missing or not being as clear as you would have liked 10 and I think to understand this, please, if we go to 11 2.1.12 in that report, that's page 7, you made a comment 12 about some missing records in relation to Werrington at 13 2.1.12. That's internal page 7, as I say. Just 14 scrolling down to 2.1.12, you said:</p> <p>15 "It is unclear from the records examined why 16 a record of entry into a child's cell was absent was 17 a particular concern, given that the child in question 18 was perceived as being of high risk in regards to 19 a propensity to make allegations against staff."</p> <p>20 There were further points about an absence of 21 recording, and then you're asked to look at that issue 22 in the context of Feltham. If we go, then, to your 23 fifth report, please, which INQ001764 and it's internal 24 page 2 and scroll in, please, on paragraph 1.3 and 25 thereafter. I think you pulled out a similar theme in</p> <p style="text-align: center;">Page 80</p>

<p>1 respect of two of the incidents at Feltham 2 from December 2012 and June 2015. Can you help us with 3 what your concern was about the lack of evidence here? 4 A. Yes, certainly. I think the issue in terms of a clearly 5 defined pathway in terms of why decisions were made, 6 which links into 1.5 in terms of the training and 7 support given to individuals who worked directly with 8 children and young people, I think for me -- it says, 9 "I can further confirm the evidence of records 10 examined" -- there were difficulties in terms of 11 disclosure and allegations of sexual abuse and I think 12 in terms of, for me, unless you get a very clear record 13 in terms of what the response was, when a child actually 14 alleged any form of abuse, but particularly sexual abuse 15 in this instance, in terms of what processes were 16 followed, what support was given, what advice was 17 sought, external working together, those sort of things 18 as well, it's very hard to spot where those things are. 19 And there were issues across some of the agencies, 20 there are examples there. Feltham, I think, from my 21 reading of the paperwork provided to me quite recently 22 in terms of the standards there and the recent 23 inspection there, seems to be doing one of those things, 24 but obviously the period of time I was looking at is if 25 the concerns were actually there, and there were</p> <p style="text-align: center;">Page 81</p>	<p>1 Q. -- when it was in an area where there was never going to 2 be any CCTV? 3 A. That's right. 4 Q. Is that your concern? 5 A. That's correct and I find that quite difficult to 6 comprehend those two things together, really. So if 7 there is an absence anyway, but there is no CCTV 8 coverage there, then those two things are separate 9 issues. 10 Q. I think Ms Willow's evidence last week was that her 11 perception was that if there's not a CCTV recording or 12 a member of staff corroborating a child's account, 13 a child would find it very hard to be believed. Does 14 that sort of fit a little bit with what you saw on this 15 allegation? 16 A. I think so. I think in terms of the reliance upon CCTV 17 coverage, these other examples in terms of it being 18 quite hard to see the alleged incident on CCTV, because 19 of the number of children around at the same time or the 20 members of staff around, so there is a reliance on that, 21 I think. I think -- and with the absence of that -- and 22 I think one of the recommendations against for Howe & Co 23 was the sort of cameras being issued to members of staff 24 and I do understand the implications in terms of 25 a child's right to having a private space and the</p> <p style="text-align: center;">Page 83</p>
<p>1 absences of records and this goes back to this issue in 2 terms of the pre-existing awareness which members of 3 staff have about children and young people and the risks 4 they may or may not present. It wasn't actually 5 utilised in a positive way. 6 Q. I think you have made a second point towards the end of 7 1.3 that there were some issues about an absence of CCTV 8 coverage in relation to some of the incidents. Can you 9 help us with what that was? 10 A. Yes, there were issues in terms of some of the instances 11 of where I had CCTV, some of the decisions were made in 12 terms of deciding not to put -- not to pursue 13 allegations against members of staff. There was no CCTV 14 coverage actually in the child's cell and that -- but 15 one of the reasons to decide not to progress is that 16 that wasn't there anyway. So it's quite hard to 17 understand why a decision was made on the basis of it 18 not being there. 19 Q. I think we heard some -- we adduced some evidence from 20 the REA that a theme that had been identified by the 21 research team here was whether or not there is, on 22 occasion, an undue reliance on CCTV and I think what 23 you're saying on that example is that the absence of 24 CCTV was used as a reason not to pursue an allegation -- 25 A. That's right.</p> <p style="text-align: center;">Page 82</p>	<p>1 cameras may impact on that, but I think in terms of 2 providing evidence and providing good evidence which is 3 not one person's word against the other, that's probably 4 the only way to do that. 5 So I think in terms of the very fact that there's 6 certain areas within the institution whereby there's no 7 CCTV, it would have been useful to see and the 8 records -- which may not have been the records I have 9 seen, it may be elsewhere in some other documents -- 10 about how the institution actually managed the risks 11 associated with those areas that weren't being covered 12 by CCTV. 13 One example we looked at earlier in terms of the 14 fact that a member of staff going into a child's cell 15 where it was known that was a high-risk issue and no 16 record being made, that adds another complicated factor 17 to it. I mean, I would suggest that if there is no CCTV 18 coverage in the cell, then records should be very 19 accurate in terms of who went in, what for, how long 20 for, who was there as a witness. 21 Q. To add to the objective pool of evidence about what 22 happened? 23 A. Yes. 24 Q. Just finally on this topic, please, 1.52 of your fifth 25 report, it's INQ001764, just bear with me a second. No,</p> <p style="text-align: center;">Page 84</p>

1 sorry, yes, it's INQ001764_010, please. I think you
 2 return to the issue of CCTV at Feltham at 1.52 at the
 3 bottom of this page and over the next page, and I think
 4 a specific example you pulled out was the
 5 9 September 2009 allegation where you said here that the
 6 decision not to pursue the allegation was made as the
 7 CCTV evidence did not support the allegation made, so
 8 there was CCTV for this incident.
 9 But then you say:
 10 "This is despite the fact that the record indicated
 11 that the footage was very unclear, given the distance
 12 and the large number of other children and young people
 13 in the area. The records do not indicate that the
 14 witnesses to the allegation were spoken to. In stating
 15 to the child or young person the seriousness of the
 16 allegation and the lack of evidence to support it, it
 17 can be argued that the message given to the child was
 18 one based upon a warning."
 19 **A. Yes.**
 20 Q. So is your concern about that, that CCTV was very
 21 unclear but was used as a reason not to pursue the
 22 allegation?
 23 **A. That's what the record indicated, yes, that it was very**
 24 **unclear and that was the reason why they didn't take it**
 25 **any further.**

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1 Q. And it didn't seem, from your perspective, that
 2 witnesses had been spoken to?
 3 **A. That's right.**
 4 Q. And I think you felt that the child might have seen this
 5 as a warning. Help us with what you mean by that?
 6 **A. I think for me, if a child alleged an incident and**
 7 **adults respond to that in terms of saying: well, we've**
 8 **got no evidence for that, and I think the words of the**
 9 **child were this is a serious thing you've said, it**
 10 **seemed to me from the record that in the absence of**
 11 **clear CCTV evidence, the fact that witnesses weren't**
 12 **actually approached or asked from what they had actually**
 13 **seen, the information was shared with the child, it was**
 14 **a serious issue to make an allegation against a member**
 15 **of staff and we've got no evidence to say this is true.**
 16 **So I think from a child's point of view I didn't**
 17 **feel like it's important that you're given the scope to**
 18 **make allegations and we take allegations in a serious**
 19 **way and we're going to investigate them to the best of**
 20 **our possible resources. It did feel to me this is**
 21 **an issue to say whether the child was actually told this**
 22 **is not a good thing to do without evidence.**
 23 **I think, for me, the impetus on the child really was**
 24 **the wrong way to handle that. The institution should**
 25 **have looked at we -- there is a gap here, why did we**

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1 **make this choice? How did we communicate to that young**
 2 **person about the allegation isn't going to go any**
 3 **further? Well, the record didn't actually sort of show**
 4 **that.**
 5 Q. I think another example of a lack of documentation,
 6 albeit in a slightly different context, was brought out
 7 by you at 3.1.17 of your first report, please. It's
 8 INQ001210, individual page 10, please, and it's
 9 paragraph 3.1.17.
 10 Now, this is a serious allegation of rape that had
 11 been made against a member of staff. You make the point
 12 here there was a very brief record of it. A section 47
 13 strategy meeting was held within which the decision was
 14 taken that there was insufficient evidence to contact
 15 the local authority where the alleged perpetrator lived
 16 and I think your concern was not only that this wasn't
 17 followed up further, but that there wasn't a clear
 18 reason for why that was. Is that a fair summary?
 19 **A. It is a fair summary, yes, and, again, I think for me,**
 20 **if those records about decisions and processes were held**
 21 **elsewhere then that should be cross-referenced here,**
 22 **otherwise it looks as if on the face, looking at what's**
 23 **actually happened, a serious allegation was actually**
 24 **made, a strategy meeting was held in this circumstance**
 25 **and decision was made at that point there wasn't**

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1 **sufficient evidence at that point, which, again, goes to**
 2 **the definition of what an investigation actually is, so**
 3 **is it internal, is it a LADO investigation, is it**
 4 **a social care investigation, is it a joint**
 5 **investigation, is it a police investigation, is it**
 6 **an investigation under section 47 of the Children Act?**
 7 **So it's unclear in terms of why that choice actually was**
 8 **made.**
 9 **I suppose coming from a point of view whereby**
 10 **I would record things expecting the child to view the**
 11 **record at some point in the future, I'd want**
 12 **an explanation about why the decision was made.**
 13 Q. You have made the point in your fifth report, please,
 14 paragraph 1.19, it's INQ001764_004 that there were
 15 several similarly serious allegations among the
 16 paperwork that you saw. I think you have said at 1.19
 17 that the record did indicate a serious allegation being
 18 made by a child or young person ringing Childline in
 19 respect of witnessing another child being raped by other
 20 children or young people in the shower.
 21 And you summarise there the other serious
 22 allegations, particularly serious allegations that you
 23 had looked at, including a nursing member of staff
 24 sexually abusing a child during an examination,
 25 a custody member of staff during a search, a custody

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<p>1 member of staff raping a child or young person in the 2 cell and those are, I think, a summary, is this right, 3 of the more serious of the allegations that you looked 4 at? 5 A. That's right, yes. 6 Q. You make the point that there were, I think, you say 7 there, no substantiated allegations, albeit I think in 8 fairness earlier you suggest that one -- 9 A. One. 10 Q. -- of them was. 11 A. That's correct, yes. 12 Q. On 9 September 2009. 13 A. Yes. 14 Q. And you go on within this report, then, to deal with the 15 Social Services involvement. Can I ask you to look at, 16 please, 1.39 in your report. It's internal page 8 and 17 I think you broadly said that just above 1.39, forgive 18 me, in around 50 per cent of the cases from Feltham the 19 Social Services or LADO had some involvement. Is that 20 right? 21 A. That's correct, yes. 22 Q. But then you go on to indicate concerns, I think, 23 overall about the section 47 threshold and about the 24 substantive involvement of the LADO service so help us, 25 please, with your themes about that?</p> <p style="text-align: center;">Page 89</p>	<p>1 LADO. You said at 3 that a generic theme was the use of 2 internal investigations. Where allegations were made 3 against members of staff the LADO was contacted although 4 not present on one occasion at Werrington. 5 Investigations under section 47 were a rarity across all 6 the institutions, but in comparison to Medway, Feltham 7 appeared to have a low rate of substantive involvement 8 from the LADO. 9 So that was one particular Feltham-related theme. 10 Is that right? 11 A. That's correct, yes. 12 Q. And then finally, please, help us with your evidence. 13 If we can go back to 1.41 in the report, it's internal 14 page 8, where you were asked some questions about the 15 police investigation. 16 A. Yes. 17 Q. You have said here in Feltham none of the allegations 18 were substantiated, none have substantive police 19 investigations, none were subjected to section 47 20 investigations. 21 A. Yes. 22 Q. Help us with what you mean, please, by "substantive 23 police investigations"? 24 A. Certainly, yes, I'm happy to do that. My perception of 25 substantive police involvement was actually a section 47</p> <p style="text-align: center;">Page 91</p>
<p>1 A. I think for me it's the issue is linked to when the 2 decision is made to refer to LADO or straight to social 3 care, the process around from a LADO point of view in 4 terms of the threshold they may want to apply to the 5 information they have, from a social care point of view 6 in terms of ensuring that section 47, the requirements 7 are actually met. 8 I'll go on further to, I suppose, a bit later on the 9 report, to say that given the additional risk factors 10 and the exposure to risk and the past history of some 11 children and young people, it's my view, I suppose, that 12 section 47 should start as a default position and then 13 work backwards from that with instances against 14 allegations against a member of staff. 15 So I think, for me, it comes back to, again, in 16 terms of this diverse range of responses and I suppose 17 what was of concern to me was it may be the situation 18 that in response to an allegation a child has made may 19 take a particular route depending on who that allegation 20 is actually made to, so the consistency of approach is 21 hard to see. That's my overarching view, I suppose. 22 Q. I think if I can go, please, to the last but one page of 23 that report, it's internal page 12, please, under 24 heading 3. You pull together, I think, a generic theme 25 was around the involvement of Social Services and the</p> <p style="text-align: center;">Page 90</p>	<p>1 approach, so I know one example's been given in terms of 2 the police interviewing a young person, looking at CCTV 3 coverage, analysing rotas, those sort of things, as 4 well. 5 I think for me it is, from the records it actually 6 is quite hard to see what actually happened to reach 7 allegation which was made. I do take the point in terms 8 of substantive police investigations may be the fact 9 that they took their own investigation. To me, this 10 again comes back to the difficulties in terms of trying 11 to separate out what people mean by allegations, 12 investigations. 13 Q. Who is doing what. 14 A. Who is doing what, and when and why. So I think in 15 terms of the example given, I suppose, my view about 16 substantive involvements isn't just attending a strategy 17 meeting. That isn't substantive involvement from any 18 agency; that's their statutory responsibilities to do 19 that. So substantial involvement would mean to me in 20 terms of undertaking a very clear process under 21 section 47 of the Children Act. And, again, it's hard 22 to see where that actually is tracked across all the 23 documents. 24 Q. So is there a difference in the language that you're 25 using, then, between substantive police investigation</p> <p style="text-align: center;">Page 92</p>

<p>1 and no police investigation?</p> <p>2 A. There is, yes, and I think, for me, the investigating</p> <p>3 sort of process needs to be analysed under one view, so</p> <p>4 section 47 is the most convenient way to do that in</p> <p>5 terms of cross -- from agencies' point of view.</p> <p>6 It links into, into me in terms of agencies</p> <p>7 undertaking their own internal investigations as well,</p> <p>8 so it is quite hard on each individual allegation being</p> <p>9 made to see who was involved when and why and what</p> <p>10 involvement -- what actually meant, but I do agree with</p> <p>11 the MPS's view that the example which they gave is</p> <p>12 example of police becoming extremely involved in a case.</p> <p>13 My understanding was that may not have been under</p> <p>14 section 47 of the Children Act.</p> <p>15 Q. I think, in terms of your background, do you yourself</p> <p>16 have experience of conducting police investigations in</p> <p>17 custody?</p> <p>18 A. I do. In terms of from my angle on that, yes, I would</p> <p>19 do, yes, so I have undertaken those. I mean, I have</p> <p>20 conducted joint investigations with police myself and</p> <p>21 police -- and joint investigations and that includes</p> <p>22 allegations against members of staff and also</p> <p>23 allegations whereby there's an organised view from abuse</p> <p>24 so wide -- a wide ranging group of adults, as well,</p> <p>25 within particular areas, as well.</p> <p style="text-align: center;">Page 93</p>	<p>1 You have heard evidence, I think, about the review</p> <p>2 of the pain-inducing techniques that has been carried</p> <p>3 out by the Youth Justice Board. Can you give a view</p> <p>4 from your own perspective of what you consider the</p> <p>5 effect may have been of pain-inducing restraint on</p> <p>6 children's willingness to disclose abuse and perhaps,</p> <p>7 more generally, from what you have seen in these case</p> <p>8 studies?</p> <p>9 A. Yes, I'd be very surprised if a child responded in</p> <p>10 a positive way to understand that the reason why</p> <p>11 restraint happened, no matter how much you explain to</p> <p>12 a child the reason why, a positive response is actually</p> <p>13 quite hard to see afterwards. So therefore that would</p> <p>14 sort of show to me that a child's previous experience is</p> <p>15 based upon adults harming them, abusing them, trying to</p> <p>16 control them, which may be pre-existing, their</p> <p>17 experience from wherever they are, Feltham or Werrington</p> <p>18 or anywhere, it's going to add to their sense of adults</p> <p>19 can impose their power in a certain way.</p> <p>20 It's not going to assist a child feeling comfortable</p> <p>21 or confident in talking to that member of staff about</p> <p>22 an allegation of sexual abuse. That's my perception.</p> <p>23 I mean, it is a very difficult role to do to restrain</p> <p>24 a child. No matter how careful you are, it does</p> <p>25 actually mean that adults imposing their power and</p> <p style="text-align: center;">Page 95</p>
<p>1 I've also had to remove children from various</p> <p>2 situations with police involved, undertaken Achieving</p> <p>3 Best Evidence interviews and I've supplied to courts for</p> <p>4 a wide range of orders, which is -- normally is</p> <p>5 a consequence of the police exercising their powers to</p> <p>6 remove a child under extreme circumstances, so I have</p> <p>7 done those things, yes.</p> <p>8 Q. So just trying to distill it, then, you remain of the</p> <p>9 view that there were questions, if I can put it</p> <p>10 neutrally, about the substantive police involvement in</p> <p>11 some of these allegations. Is that right?</p> <p>12 A. I think, for me, the example which is given is a clear</p> <p>13 example of what they actually did. For me, without</p> <p>14 examining the entirety of records across police records,</p> <p>15 which may add additional factors, with the information</p> <p>16 I have seen, which I would expect, since a child's</p> <p>17 actually "resident", in inverted commas, there, that</p> <p>18 should be the core element of where all the records are</p> <p>19 actually cross -- sort of -- referenced from my</p> <p>20 perspective, anyway.</p> <p>21 It is quite hard to see the level of involvement</p> <p>22 across a range of issues, not just from the police but</p> <p>23 from social care, from LADO, all agencies involved.</p> <p>24 Q. Just one final question, chair, if I may, from</p> <p>25 Howe & Co, please.</p> <p style="text-align: center;">Page 94</p>	<p>1 control over that child.</p> <p>2 Q. Thank you. And just finally for completeness I should</p> <p>3 just read in the reference for the MPS material. It's</p> <p>4 OHY003322, and that's the example you were given of</p> <p>5 various steps the Met Police had taken on a</p> <p>6 particular --</p> <p>7 A. That's right, yes.</p> <p>8 MS HILL: Thank you, chair. Those are my questions for the</p> <p>9 witness.</p> <p>10 THE CHAIR: Thank you. We will take a lunch break now and</p> <p>11 return at 2.00.</p> <p>12 (1.05 pm)</p> <p>13 (The luncheon adjournment)</p> <p>14 (2.00 pm)</p> <p>15 MS HILL: Thank you, chair. I will call, please,</p> <p>16 Glenn Knight.</p> <p>17 MR GLENN KNIGHT (sworn)</p> <p>18 Examination by MS HILL</p> <p>19 MS HILL: Thank you very much. You're Glenn Knight; is that</p> <p>20 right?</p> <p>21 A. Yes, that is correct.</p> <p>22 Q. You're here to give evidence because, is this correct,</p> <p>23 until May of this year you were the governing governor</p> <p>24 at Feltham?</p> <p>25 A. Yes, I was.</p> <p style="text-align: center;">Page 96</p>

<p>1 Q. You're hoping to assist the panel, I think, with some 2 general background to the systems in place for 3 safeguarding children at Feltham and also to try and 4 assist with the response to some of the issues that 5 Mr Wood has identified. Is that right? 6 A. That is correct. 7 Q. You have provided a statement dated 13 July which I will 8 adduce, please, with your permission, chair, HMP000407, 9 which sets out a bit of the background in relation to 10 Feltham. Mr Knight, can you tell us a little bit about 11 the two different parts of Feltham and what they are and 12 things like that? 13 A. So Feltham has two sides, so it has Feltham A, which is 14 where we care for up to 180 young people and that will 15 be from the age of 15 to 18, and then it would have 16 Feltham B, in which we'd care for, fully operational, 17 522 young adults and that would be the age from 18 to 18 21. 19 Q. Feltham A has young people who are both sentenced and on 20 remand. Is that right? 21 A. Yes, it does. 22 Q. Then tell us a little bit, please, about the different 23 units within Feltham A? 24 A. So on Feltham A you have an induction unit where all the 25 children and young people would come initially. You</p> <p style="text-align: center;">Page 97</p>	<p>1 sexualised behaviour or self-harm. Is that right? 2 A. Yes, that is correct, yes, there will be a complete 3 multidisciplinary assessment on both of those young 4 people. 5 Q. You were asked some questions, Mr Knight, about the 6 inspector's report of Feltham in 2017. If I could bring 7 that up, please, it's INQ000125? 8 MR FRANK: Ms Hill, I wonder if I could ask you -- I am 9 having difficulty finding this in my bundle. 10 MS HILL: Just bear with me a second. I understand that you 11 have the statement for Mr Knight in your bundle. 12 I don't think you have his exhibits or the supporting 13 documentation. Just bear with me a second, please, 14 I think you have his statement should be, it's 15 section 33, tab D, the index may not have yet caught it 16 up, I'm sorry. 17 MR FRANK: Thank you very much. 18 MS HILL: But I think the inspectors report I am about to go 19 to is at tab C. 20 Thank you, if I could pull up the 2017 report. As 21 I say it's INQ000125 and just to take this relatively 22 briefly, Mr Knight, because I know this isn't the most 23 recent report, could I pull up, please, internal page 5 24 which sets out a broad introduction to the report. 25 This was a report with Peter Clarke, HM</p> <p style="text-align: center;">Page 99</p>
<p>1 also have the living units where we would care for up to 2 30 young people on those units and just recently we have 3 introduced an enhanced support unit, which is a small 4 unit that would care for the young people, the most 5 challenged and challenging needs. 6 Q. Help us, please, with whether children share a room or 7 whether or not there are double rooms? 8 A. So the majority of the rooms are single. We do have 9 some rooms that can be shared, but that would be on 10 a risk assessment basis or a cell share risk assessment 11 would take place, and that would normally be only with 12 boys that have reached an enhanced level or if they're 13 an insider and we felt like some additional young person 14 would need additional support. But there are only one 15 of those on each of the units and they're used very 16 infrequently. And if they would be used, as I said, it 17 would be documented and risk assessments would be taking 18 place. 19 Q. I think, Mr Knight, you give a specific example of one 20 of the double rooms being shared by two young people who 21 had been at Feltham for a long time and developed 22 a friendship and their sharing arrangement was agreed 23 after careful consideration of their offences and their 24 conduct in custody. You suggest that the process of 25 doing that ensures that there were no risk indicators of</p> <p style="text-align: center;">Page 98</p>	<p>1 Chief Inspector of Prisons and, is this right, there 2 were a range of concerns raised in the report about 3 levels of violence and the use of force having 4 increased, for example? 5 A. Yes, there was. 6 Q. Some of the violence was very serious. There was 7 a concern about the restrictions on the regime and 8 I think, by way of trying to pull the different threads 9 together towards the end of this page, "There was 10 an extent", it says, under the penultimate paragraph, 11 "to which Feltham A was a place of contrast. There was 12 no doubt staff working in very challenging circumstances 13 yet most of the interactions we observed between staff 14 and the boys were polite. Inevitably, relationships 15 were hindered by the lack of time for meaningful contact 16 because of the amount of time the boys were locked up. 17 Healthcare was good. The work of the mental health team 18 was good." 19 It goes on to say it would be wrong not to recognise 20 the challenges faced by staff at Feltham A, but overall 21 it said that violence was a serious problem: 22 "The current approach is failing to deliver that 23 reasonable expectation and from the evidence available 24 to us is actually making it worse." 25 And concluded over the page by observing at the top</p> <p style="text-align: center;">Page 100</p>

<p>1 of internal page 6: 2 "One should not be surprised at the failure to 3 improve when a mere 11 of the 55 recommendations made at 4 the time of the last inspection had been fully achieved. 5 34 were not achieved. Nine were partially achieved. 6 I would urge the leadership at both Feltham A, HMPPS and 7 the Youth Justice Board to study this report carefully 8 and on this occasion to take its recommendations 9 seriously." 10 Just going further through the report if I may, 11 please, section 1 of the report, we can see summarised 12 on internal page 13. That deals with safety overall and 13 it's right, isn't it, that in the box at the top, 14 "Safety overall", the outcomes for children and young 15 people were poor against this healthy prison test. That 16 was the result in 2017? 17 A. Yes, that is correct. 18 Q. Then, if one looks at internal paragraph 1.17 on 19 internal page 23, please, the heading "Child 20 protection": 21 "The findings of this report were that the 22 establishment protects children and young people from 23 maltreatment by adults or other children and young 24 people", was the expected outcome, but against that 25 measure 19 child protection referrals had been made.</p> <p style="text-align: center;">Page 101</p>	<p>1 a number of reasons, really. We completely relooked at 2 our behaviour management strategy. One of the issues 3 and concerns we had was around staffing. We did 4 actually invest in some staff training but, more 5 importantly, our own localised recruitment process, so 6 that helped and there is a midpoint pay rise as well. 7 So, in effect, prison officers get paid more to work on 8 Feltham than they were in other establishments. 9 Q. Let's just perhaps deal with this as we can in your 10 statement, please, it's HMP000407 and internal page 3, 11 please. 12 Just to try to put a bit of flesh on this, 13 Mr Knight, you have explained here in your witness 14 statement that you designed an action plan -- that's 15 exhibit GK1 -- to respond to the report. 16 A. Yes, he did. 17 Q. You have provided the most recent report at your 18 exhibit GK2 and, in fact, I think you extract part of 19 the report at paragraph 10. Perhaps we can just scroll 20 in over the page on that. This report noted that work 21 to support the boys was reasonably good. Safeguarding 22 and child protection systems were sound. Instances of 23 self-harm were lower than comparators. A clear focus on 24 reducing violence led to an impressive reduction in 25 assaults on boys and staff. Levels of violence were</p> <p style="text-align: center;">Page 103</p>
<p>1 The majority continued to relate to the use of force 2 by staff. Evidence that investigations were delayed 3 unnecessarily because some staff were confused about the 4 procedure for notifying the establishment safeguarding 5 team. The potential for delaying timely action to 6 prevent further harm was concerning. The safeguarding 7 team referred allegations to the LADO within 24 hours." 8 And there was evidence about the subgroup remaining 9 useful but there was obviously a concern being expressed 10 there that not all staff were aware of the child 11 protection procedures. Is that right? 12 A. Yes, that's correct. 13 Q. There were various other parts of the report that dealt 14 with issues such as the level of violence, support for 15 victims and things of that nature, that I perhaps don't 16 need to come to. But is this right, that Feltham has 17 taken steps to try and address those findings and 18 accepted the concerns that were expressed? 19 A. Yes, we did. Yes, we took all of the recommendations 20 very seriously from memory out of the 47 that was 21 connected to safety, 22 of them we achieved in the 22 recent inspection and 15 we partially achieved and 23 I think you can see from my statement that the "poor" 24 score was actually improved to "reasonably good", so 25 from a 1 to a 3, and that's pretty much because we --</p> <p style="text-align: center;">Page 102</p>	<p>1 still too high. Systems to challenge bullying and 2 support victims required greater management oversight at 3 unit level. A promising new behaviour management 4 strategy was showing some early results. Use of force 5 was proportionate, governance was good. 6 Then some other observations. So the outcome 7 overall was that children and young people, it was 8 a reasonably good grade on safety. Is that right? 9 A. That's correct, yes. 10 Q. You have indicated that in announcing the results of 11 that further inspection, the Chief Inspector welcomed 12 the work that had been done by Feltham. Is that 13 correct? 14 A. Yes, he did. 15 Q. You have provided, at GK3, the press release to that 16 effect. So just to help us understand a little bit, 17 you've mentioned some of the recruitment issues and the 18 pay issues, but help us understand a little bit more 19 about the nuts and bolts of the action plan and what you 20 have implemented. 21 A. So all the recommendations would actually be linked to 22 an action plan, so we would look at those individually, 23 but if I talk about the whole focus and the strategy, 24 yes, we had two priorities. One was award safety and 25 ensuring that all of the young people that we care for,</p> <p style="text-align: center;">Page 104</p>

<p>1 the staff and all visitors are kept as safe as possible 2 and how we improved safety was we had a complete review 3 of our behaviour management strategy. We also 4 introduced a restraint minimisation plan. 5 We also need to actually get a sense of community 6 because somebody actually said to me once, "You don't 7 have an issue with violence at Feltham. You actually 8 have an issue with conflict", and what we found is the 9 children and young people did at times, understandably, 10 given their age, struggle to deal with conflict, so we 11 introduced the restorative justice and we got conflict 12 practitioners that help then deal with conflict. 13 We also tried to get a sense of community, as well 14 and anybody that has worked with young people would know 15 that actually awarding sanctions, sanctions don't work, 16 you have to have clear boundaries, but what we have 17 realised is, actually, reward works more, so you have to 18 reward somebody seven times – sorry, sanction somebody 19 seven times unless you give a reward. So what I would 20 say is we have completely reversed our policy. So young 21 people were rewarded if they behaved and kept 22 boundaries, they were given the tools to deal with their 23 conflicts and, on the whole, there was a sense of 24 community. Our enhanced, sort of, earned privileges 25 scheme, we introduced three levels, bronze, silver and</p> <p style="text-align: center;">Page 105</p>	<p>1 Q. You've endeavoured, I think, to have the prison staff 2 engage more proactively with partner agencies such as 3 healthcare, psychology, the local authority and youth 4 support services in a range of ways, is that fair? 5 A. Yes, it has to be a whole-establishment approach, 6 multidisciplinary, completely. 7 Q. Then help us, please, a little bit with the safeguarding 8 training that staff are given and the extent to which 9 that is compulsory and fully complied with or the 10 training is done, at least. 11 A. So we call it POELT, so prison officers who are new to 12 the role now, we do our own POELT training for all those 13 staff that work with young people. Safeguarding is 14 a key part of that initial training, but of course we 15 have existing staff, so we would look to do our own 16 local training and raising awareness. As I have said in 17 my statement, of course, would I want every single 18 member of staff to ensure they have carried out that 19 out? Yes, definitely. Are there some staff that it may 20 not have happened because of sickness when we have put 21 the training on? Yes, so should I say that 100 per cent 22 of the staff have been trained in no but we do put 23 an emphasis on that. 24 But also just raising awareness, so we have had the 25 LADO come in and we have introduced themed briefings</p> <p style="text-align: center;">Page 107</p>
<p>1 gold, but also a platinum level which meant the children 2 and young people that would work as a community could 3 actually do additional tasks like Duke of Edinburgh. So 4 there was a complete change and refocus, and I must say 5 the reason we would be able to do that, to be honest, 6 because the second priority has always been resource and 7 our biggest resource of anybody that works in 8 an institution like Feltham is the staff and, without 9 the staff given the correct tools to do their job, the 10 right amount of staff that we had and motivated and 11 trained, it's very difficult to achieve anything at all. 12 So those were the two priorities that I set, it 13 directs the travel and I'm pleased to say the 14 inspectorate recognised us. 15 Q. A few points of detail, you make the point in your 16 witness statement at paragraph 12 that as at the end 17 of June this year Feltham A was fully staffed. Is that 18 right? 19 A. Yes, it was, yes, it's probably the first time I've ever 20 known Feltham to be fully staffed yes. 21 Q. And you've indicated that around 40 staff members have 22 taken up place on the foundation degree about which we 23 have heard. 24 A. Yes, they have, so people have volunteered and are 25 taking up those places.</p> <p style="text-align: center;">Page 106</p>	<p>1 once a week. So they actually give a briefing to 2 managers and to staff. 3 Q. And you think that's led to positive outcomes? 4 A. Definitely, yes, I think raising awareness and raising 5 training, because it's not about individuals, as I have 6 said, it's a whole-establishment approach. 7 Q. I think you've indicated that the current child 8 protection policy for Feltham which I think we have -- 9 just bear a second, LOM000004_001, perhaps you could 10 bring that up briefly. That's June 2015 but I think you 11 have indicated that that is going to be updated in light 12 of Working Together 2018, which you now have. Is that 13 right? 14 A. There are more modern versions than the 2015, but the 15 current one which gets reviewed annually, we have just 16 been given the Working Together practice guide, so it's 17 due to review in July and that's happening as we speak, 18 yes. 19 Q. I see. Just for completeness, please, can I formally 20 adduce, and just perhaps bring it up briefly, the action 21 plan that you referred to, your exhibit GK1 is 22 HMP000408. Let's see if we can bring that up, briefly. 23 I think if you go to the next page, please, and the 24 panel can look through that in due course, but just for 25 completeness, it's fair to say that that has a series of</p> <p style="text-align: center;">Page 108</p>

<p>1 actions numbered in the left-hand column, and it runs 2 through to some 81 different action points. Is that 3 right? 4 A. That's correct, yes. 5 Q. We can see on it the target dates, who is responsible 6 and things of that nature. The panel can look at that 7 in their own time, perhaps. 8 A. Yes, they can. 9 Q. Your exhibit 2, HMP000409, perhaps the second page, that 10 is the most recent HMCIP -- his inspection report from 11 earlier this year, HMCIP, and we can see, if the panel 12 look into that, internal page 5, please, gives the more 13 positive overall response than the previous report. Is 14 that right? 15 A. Yes, it does. It's actually showing the glossary of 16 terms, I think it's the next page, actually. 17 Q. It's my internal page 5. That's it. Forgive me. The 18 panel can, again, read that, but this is the report that 19 you were no doubt pleased to see. 20 You have referred -- just to formally exhibit it, we 21 don't need to bring it up, I think -- to the press 22 release from the Chief Inspector. That's at your 23 exhibit GK3, HMP000410. The headline is: 24 "HM YOI Feltham A. 'Children and young people 25 significantly safer', says chief Inspector."</p> <p style="text-align: center;">Page 109</p>	<p>1 levels of responsibility, who's responsible, Working 2 Together across local authorities and internally, as 3 well. 4 Q. I think you have dealt with this in your witness 5 statement at paragraph 37 but this process applies, is 6 this right, when a member of staff is the recipient 7 of an allegation of sexual abuse and other things? 8 A. Yes, yes, it is, yes. 9 Q. The intention is that this will be reviewed in 10 accordance with the most recent Working Together 11 document, but its intention is to set out a clearer 12 process for how to respond to allegations against 13 members of staff? 14 A. That's correct, yes. 15 Q. And then, finally, your GK7, which is HMP000414 and it 16 will be the second internal page in that. This is 17 a risk assessment matrix, I think, an RAM that's been 18 designed in early 2018, which was, again, referenced in 19 the most recent Chief Inspector's report. What is your 20 understanding of what this document does? 21 A. So this is a local document we introduced, just, again, 22 for clarity really, so this is around setting -- it's 23 looking at risk around individuals as well, so the risk 24 assessment process could be if it's -- if there is 25 a concern or an issue, but it's around training, that</p> <p style="text-align: center;">Page 111</p>
<p>1 You've also referred to the safeguarding strategy. 2 I will bring that up because the panel may wish to look 3 at that. That's HMP000411. That's a September 2017, 4 next page, please, sorry is the internal page 2. That's 5 a September 2017 strategy for safeguarding. So it 6 postdates, does it, all of the allegations that Mr Wood 7 looked at? 8 A. Yes, it does, yes. 9 Q. Then, for completeness, please, HMP000413 and it will be 10 the second page. This is a perhaps -- no, forgive me, 11 sorry, it's 412, I think. This is GK -- yes, that is 12 right, this is the perhaps allied strategy which is 13 around restraint minimisation? 14 A. That's correct, yes. 15 Q. Then help us, please, with these last two documents. So 16 GK6, which is 413, this is a new document agreed, 17 I think, with the London Borough of Hounslow. So help 18 us a little bit, please, with that? 19 A. I mean, so this is our local protocol that we have 20 agreed jointly with the local Borough of Hounslow. 21 Q. What does this assist in the panel -- the panel in 22 understanding, what does this apply to, how does it work 23 in practice or how is it anticipated it will work in 24 practice? 25 A. This just makes it clear that it actually sets out</p> <p style="text-align: center;">Page 110</p>	<p>1 could be highlighted, to the most serious concern where 2 a member of staff may have to be suspended or obviously 3 from police involved. 4 So it's just a framework in a document where we can 5 actually manage risk and it can be documented almost 6 like a decision log, really, around how we have come to 7 the process of making those decisions around that 8 individual case and member of staff. 9 Q. Is the hope that the risk assessment process here looks 10 at both the needs and vulnerabilities of the child, but 11 also part of this process is to consider whether or not 12 someone should be suspended, it's to help make decisions 13 of that nature? 14 A. Yes, I mean, the child has to be the centre of all of 15 these processes. So, yes, it's a way of that being 16 documented as well and, more importantly, evidence. 17 Q. If I have understood it correctly, if one looks at the 18 document, this is a document that is filled in about 19 a member of staff. Is that right? 20 A. That's correct, yes. 21 Q. And so it is a way of tracking how many safeguarding 22 referrals have been made in relation to a particular 23 member of staff. Is that right? 24 A. It can be used in that way as well, yes, so it will 25 certainly be on record.</p> <p style="text-align: center;">Page 112</p>

<p>1 Q. I am just looking at the form. It has "Staff name" at 2 the top? 3 A. Yes, it would. 4 Q. But this is about a member of staff, so it's to try to 5 track, is it, the risk that they pose or are perceived 6 to pose? 7 A. Yes. 8 Q. So if an allegation is made by different children -- 9 allegations are made by different children against the 10 same member of staff, this form should help capture 11 that. Is that right? 12 A. Yes, it would, yes and obviously we would have that 13 information and we could look back and track back and 14 see how many times are there things that need to be done 15 around training or is it repeat occurrences or are there 16 serious concerns? 17 Q. And things such as their last MPR refresher and actions 18 that are taken about them are noted on this form. Is 19 that right? 20 A. Any action that will be taken but that could be one 21 example, yes. 22 Q. Your final exhibit, please, I think is your GK8 that's 23 HMP000415 and that is a, I think in fairness, still 24 draft service level agreement, next page, please, 25 a service level agreement between the Met Police,</p> <p style="text-align: center;">Page 113</p>	<p>1 Q. Can I just move now to some other of the points of 2 detail that Mr Wood has raised. As you have heard, he's 3 given various views about the use of the complaints form 4 and I think he's accepted that complaints are but one 5 way in which children might disclose child sexual abuse. 6 Can you offer your perspective on this issue, please? 7 A. Yes, the complaints is just one source and, again, 8 I think we have listed it in my statement but the 9 children that we care for at Feltham have a number of 10 avenues as well from their CuSP officers or personal 11 officers, from education, from our social workers, 12 healthcare, the IMB, our advocacy service from 13 Barnardos, the list is endless. We've got youth 14 workers, Connected Youth come in, Road Light, so we have 15 lots and lots of individuals and lots of agencies and 16 organisations that they actually could raise a concern 17 to. 18 Q. I think you have considered whether or not the complaint 19 form which is, in fairness -- I'm sure the panel 20 understand -- a generic form that children can use to 21 complain about anything, whether or not there should be 22 a specific section about sexual abuse on the form, and 23 what is the view that you have given about that? 24 A. So if I'm being honest, my view is I don't think that 25 would be appropriate, would work, so these are generic</p> <p style="text-align: center;">Page 115</p>
<p>1 NHS England, The Havens and HMPPS about, if one looks in 2 the middle of the page, responding to serious sexual 3 offences within prison establishments in London. You 4 can see the purpose is "to standardise the interagency 5 responses to sexual offences within prison 6 establishments in London." 7 So it applies to the adult estate as well, I think. 8 Is that right? 9 A. It does, yes, that's correct. 10 Q. Do you have a sense of when this SLA will be finalised 11 and operational? 12 A. To be honest, I don't, because I'm -- my new job now, 13 I'm a sort of interim prison group director for the IRC, 14 so I've left Feltham since May. I was just speaking to 15 my colleague earlier and it is still being discussed, 16 but it would be wrong of me to put an exact date of when 17 it's going to be finalised, and I wouldn't be signing 18 it, so it would be obviously the new governor of Feltham 19 but I think we're talking -- we're talking weeks rather 20 than months or years, so ... 21 Q. Is it your understanding that part of the rationale for 22 that document is to give a clearer understanding of the 23 roles of the various agencies involved when a serious 24 sexual assault allegation is made in custody? 25 A. Yes, it is. Just needs clarity for all agencies --</p> <p style="text-align: center;">Page 114</p>	<p>1 forms that young people can use and these are in view 2 for everybody to take, so they can have free access to 3 them and I just think having a box on there, I'm not so 4 sure a child would actually tick that box or feel 5 comfortable about it, so I just think we understand that 6 it's a generic form, but there is another option, there 7 is a stage 2, so confidential access. 8 Q. That's a COMP 2 not a COMP 1, is that right? 9 A. So there is a COMP 2, which is a confidential access 10 form and we would provide envelopes next to those 11 complaints, so actually they get sealed in an envelope 12 and they can either be opened by the governor or they 13 can also be to my boss, the deputy director of custody. 14 So that's a form that no one has access to apart from 15 very senior people. 16 Q. I think you make the point -- is this right? -- that if 17 a COMP 1 is filled in, that the complaints clerk who 18 receives those complaints does have child protection 19 training and so should know to direct that sort of 20 allegation of abuse if that's what's made in the 21 complaint to the safeguarding team? 22 A. Yes, they would know to the safeguarding team child 23 protection officer or, if a complaint was dealt with at 24 a weekend, it would be the duty governor, because 25 obviously they're the most senior person that would deal</p> <p style="text-align: center;">Page 116</p>

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

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

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

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

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1 an issue, and if there is a restraint, immediately now,
 2 depending what would happen, they will already be seen
 3 by a nurse and the duty governor. Then there would be
 4 very quickly a follow-up debrief from a member of the
 5 safeguarding team and from that, you know, I also chair,
 6 as the governor, or the deputy governor in my absence,
 7 a weekly governance meeting where we would look at all
 8 the incidents that happen on Feltham A and one of the
 9 key questions would always be, what support mechanisms
 10 are in place for this child? Is there issues to support
 11 the staff, as well, is it a training issue? Is it
 12 a serious concern? Is it a CP? Have we referred it
 13 out?
 14 So that is minuted --
 15 Q. That means it is a child protection case?
 16 A. Sorry, child protection case. So all of that would be
 17 minuted and all of that would be documented in that
 18 weekly meeting, but prior to that, all of the MMPR
 19 coordinators and safeguarding officers would have
 20 already spoken to that young person and, again, it could
 21 be that if that young person has had a number of times
 22 and there has been a restraint, so we would look at --
 23 we would look at the situation around that. It could
 24 be, if they do have an issue with anger or dealing with
 25 conflict, we have a whole suite of interventions that we

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1 could try and help that child to deal with that, or if
 2 it's a specific concern around a unit, individual
 3 members of staff, of course we would look at that as
 4 well.
 5 What I would say is there is a government structure
 6 that's highlighting inspection now, where we robustly
 7 monitor all of these complaints, and the child is centre
 8 in all of that.
 9 Q. I think you make the point, at page 12 of the most
 10 recent inspectors report, that Feltham processes for
 11 governance around restraint were commended?
 12 A. Yes, they were. Yes.
 13 Q. You have made the point in your witness statement that
 14 staff do receive training on the complex needs and
 15 vulnerabilities of children and are trained to use
 16 physical restraint as the last resort in this context.
 17 Is that right?
 18 A. Yes, it would always be the last resort.
 19 Q. And you've made the point that if, as governor, on
 20 reviewing any restraint incident, you were concerned
 21 about the use of force, you would convene a strategy
 22 meeting and follow the child protection process.
 23 I think that when you said, "Is it a CP?", that's what
 24 you meant. Is that right?
 25 A. Yes, we would. Or, yes, I would.

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1 Q. Is there anything else that you believe is necessary for
 2 Feltham to improve its systems for responding to
 3 allegations of sexual abuse?
 4 A. I think we could always improve. I do think actually
 5 the new 2018 Working Together, I think our policies do
 6 have to be reviewed and refreshed around that. I think
 7 we can only ever keep doing what we're doing to actually
 8 ensure that every member of staff, every young person
 9 and child and visitor has an understanding about this
 10 policy and, more important to me, certainly know how to
 11 signpost or flag it up. Again, our support mechanisms,
 12 would I like more social workers? Of course I would.
 13 Would I like more staff so we could interact with young
 14 people? Of course. You have heard about reform.
 15 Resources coming more to YOIs now and we're starting to
 16 see that. So I wouldn't say, yes, we have got there and
 17 we can't improve, because I don't think you could ever
 18 improve, certainly around this subject -- enough, sorry,
 19 improve enough.
 20 MS HILL: Chair, those are all my questions.
 21 Questions by THE PANEL
 22 THE CHAIR: Thank you. Mr Knight, could you help us with
 23 something you mentioned: pay levels and the fact you
 24 were able to raise them in order to attract staff at one
 25 stage. For our information, could you say something

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1 about, is there parity between the pay scales and
 2 conditions in the public sector and the private
 3 providers in this area?
 4 A. So I -- I can't comment on the exact salaries in the
 5 private sector, but I can comment about Feltham, so if
 6 you looked at the local labour market, yes, there are
 7 a number of private sector establishments, Bronzefield
 8 amongst others, that were paying more, but probably one
 9 of the biggest issues that we had at Heathrow Airport,
 10 so of course it was the labour market around that, so
 11 our attrition rates were fairly high, we couldn't
 12 attract and retain staff, so we have now realised that
 13 and there has been a process and an increment and
 14 a midpoint pay range to ensure that we do get the right
 15 people and that's in line with the local labour market
 16 and specifically around Feltham and working with young
 17 people.
 18 THE CHAIR: And you have no idea what private providers pay?
 19 A. It would be wrong of me. I would be guessing if I said
 20 it.
 21 THE CHAIR: Is there interchangeability across the sectors,
 22 in terms of people moving through from one to the other?
 23 A. So, yes, not -- so you would have to resign from the
 24 private sector and then come to the public sector, you
 25 couldn't be seconded or just moved across.

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<p>1 THE CHAIR: No, no, but is there movement of staff? 2 A. Yes, yes, I have seen -- just locally, I do know of 3 staff that have come to Feltham from private sector 4 establishments, yes. 5 THE CHAIR: Thank you very much. 6 Ms Sharpling? 7 MS SHARPLING: Thank you. Just a question from me. The 8 complaint forms that you have mentioned whilst giving 9 your evidence, are they actually retained on personnel 10 files for a certain period of time? I'm just thinking 11 of those circumstances where, for example, the complaint 12 has not been substantiated or not upheld or dismissed or 13 whatever the action is, are they then retained on the 14 personnel files for a period of time? 15 A. So the complaint form is one that a young person/child 16 would complete. They wouldn't be retained in personnel 17 files. Our personnel files now are all done 18 electronically. What would happen is, let's just say 19 there was a local investigation or the police are 20 involved, there would be a note of that if an award was 21 given on individual records but there wouldn't be around 22 on personnel files to say -- 23 MS SHARPLING: What happens to the form in the end? 24 A. So the form will be kept by our complaints clerk and 25 will be filed and then it will be kept for the period of</p> <p style="text-align: center;">Page 125</p>	<p>1 are most likely to suffer from that shortage. What can 2 be done to increase the number? 3 A. What, in Feltham, or in general? 4 MR FRANK: So let's deal with Feltham, which is ... 5 A. Well, I guess this is probably somewhere above my pay 6 grade as the governor, as the governor then, so this is 7 a policy decision that people just need to consider 8 about where are resources best placed, so I think it 9 would be wrong of me to be able to say how it could be 10 done, but I think certainly there's a legal analysis as 11 well but, corporately, I understand, as you say, if we 12 get additional social workers in Feltham and the overall 13 budget isn't increased, then somebody else has less. 14 MR FRANK: I won't press you on what you can't answer. 15 Thank you very much. 16 THE CHAIR: Thank you, Mr Knight. 17 MS HILL: Thank you, Mr Knight. Thank you. 18 Chair, just before Mr Wood returns I should indicate 19 that there is a written response that's been provided to 20 the inquiry on behalf of Hounslow who are the 21 appropriate local authority for Feltham. I don't think 22 time today is going to permit reading in that evidence, 23 but please can I just formally adduce in particular the 24 witness statement from Lara Wood, head of safeguarding 25 and quality assurance for the</p> <p style="text-align: center;">Page 127</p>
<p>1 time we have to keep it, and eventually it would be 2 destroyed and put on our sort of destruction log to say 3 that this information's been destroyed, but that would 4 be in five, ten years' time, it certainly wouldn't be in 5 the next short term. 6 MS SHARPLING: All right, thank you. 7 THE CHAIR: Mr Frank? 8 MR FRANK: Just a question about the social workers that you 9 mentioned. You say you have three, I think? 10 A. Yes. 11 MR FRANK: What's optimum? 12 A. So, I mean, if there is optimum -- for me, I think we 13 could always -- we could use double that, treble that 14 but, again, I appreciate it's difficult in the 15 community, as well. So if you was -- if you were 16 talking about me, I would say, yes, actually, my view, 17 five or six would be really, really useful, but I do 18 recognise the scene around, sort of, public funds and 19 the community as well. 20 MR FRANK: One of the things you mentioned was that, 21 I think, they tend to have a direct involvement with 22 those who have already been in care, as it were. 23 A. Yes. 24 MR FRANK: And so, if there is a shortage of social workers, 25 it's the ones who have come from the care background who</p> <p style="text-align: center;">Page 126</p>	<p>1 London Borough of Hounslow, dated 2 July. 2 It's HOU000018 because that is Hounslow's detailed 3 response to the points Mr Wood has made and in due 4 course I'd ask you, chair, to read that. 5 For completeness, can I also formally adduce some 6 earlier statements from Hounslow with the following 7 references: HOU000002, 000004, 000001, 000017 and then 8 in fact Hounslow had also provided the draft protocol 9 about which we heard at 000020. In particular as I say, 10 chair, it's the response of 2 July that I'd ask you and 11 your colleagues to read in full. 12 So I will recall, please, now Mr Wood to move on to 13 deal with some issues around Werrington and, chair, what 14 I propose to do is ask Mr Wood some questions about the 15 themes he identified in relation to Werrington. Then 16 perhaps that might be the time for our break and then we 17 will hear from Mr Gormley about Werrington. 18 Thank you, chair. 19 MR ALAN WOOD (continued) 20 Examination by MS HILL (continued) 21 MS HILL: Mr Wood, help us, then, with some of the themes 22 that you identified from your review of the allegations 23 at Werrington. First of all, if I can ask you to look, 24 please, at paragraph 2.1.7 of your second/third report. 25 In fact, forgive me, before we get there, can I ask you</p> <p style="text-align: center;">Page 128</p>

<p>1 to turn up the list of allegations in relation to 2 Feltham. It's at -- Werrington. It's INQ001210 and 3 it's internal page 5, please: if we scroll in on that, 4 top of the page, please. 5 We will see there that you were invited to look at 6 ten issues, is this right, in relation to Werrington? 7 A. That's correct, yes. 8 Q. I will just wait for that to come up. INQ001210, it's 9 the report we had earlier. 10 Second and third report. Sorry if I gave you a bad 11 reference. It's internal page 5, please, and just 12 scroll in on section 2.0 at the top. That is the list 13 of dates of allegations that you looked at, so it spans 14 here a period from January 2011 to March 2016. Is that 15 right? 16 A. That's correct, yes. 17 Q. If we scroll in, please, on 2.1.1, go down there. 18 Generally, is this right? At 2.1.1, you said: 19 "With the exception of one allegation, Werrington 20 responded to allegations in a timely and structurally 21 appropriate way. There was good evidence of the 22 allegations being recorded in an appropriate manner 23 using the correct form. Generally, the recording was 24 clear and concise, but there were some issues, perhaps, 25 about the quality and appropriateness of the language</p> <p style="text-align: center;">Page 129</p>	<p>1 help us with that, please. 2 A. Yes, a couple of examples, I suppose. In terms of 3 a child's past use of the complaints procedure -- so 4 there were some examples in terms of whereby the view 5 I had was, was that sometimes the response may have been 6 framed by the view that there is a suspicion regarding 7 the purpose of why the child has wanted to make 8 a statement. 9 I think one example I drew out says there is 10 a significant potential for a disclosure not to be 11 a genuine one and that statement was made prior to any 12 investigative -- or any breakdown of what had 13 actually -- the allegation actually was. 14 So in its sole context without any meaning behind 15 that, that's quite a stark statement to make in terms of 16 being significantly potential for the disclosure not to 17 be a genuine one. 18 Now, that may have been reflective of the person 19 filling out that particular record of his or her 20 experience, but, without the additional context, 21 actually quite hard to grasp the reason why that 22 statement was actually made. 23 Q. Just for completeness, if we can turn up, please, 24 INQ001764, internal page 2. That's where you gave some 25 specific examples, I think, of this theme in operation.</p> <p style="text-align: center;">Page 131</p>
<p>1 used." 2 So just help us with what you meant by that? 3 A. Yes, certainly. I think in terms of an overarching 4 point of view, the records within this young offenders' 5 institution were of a high standard. They did show what 6 actions were looked at and what the next steps were. 7 I think for me, again, it reflects on other comments 8 I made earlier that the consistency in terms of the good 9 recording practice wasn't always matched in terms of the 10 analysis, understanding of children's needs following on 11 from that. 12 Q. So there was a better process here, is that right? 13 A. That's correct, yes. 14 Q. But there were still some concerns about the nuanced 15 understanding of the children's needs? 16 A. That is correct, yes. I think this institution tended 17 to follow one set way, so it was easier to match up 18 those initial views, as well. So I think for me, still, 19 the common theme really was that, even though the 20 recordings were there, there is still some issues in 21 terms of what it meant. 22 Q. One of the themes you pulled out, if we can go to the 23 next page, please, internal page 6 and scroll in on 24 2.1.7 and 8, one theme you elicited was a suggestion of 25 allegations being regarded perhaps with suspicion. So</p> <p style="text-align: center;">Page 130</p>	<p>1 It's the first two paragraphs on this page, please, 1.1 2 and 1.2. You were asked specifically about certain 3 allegations there, those referred to on the notes 4 SFC000007 and NOM000009, and I think you indicated that 5 they were examples of this sort of suspicion in 6 operation. Is that right? 7 A. That's correct, yes. 8 Q. I think, just for completeness, we can pull up some 9 examples of that from the letter of instruction where 10 the documents were quoted. It's INQ001733_001, please 11 and you can see, if you scroll in on the bottom 12 paragraph on that page, please, the extract from one of 13 the documents here, (i), I think, where there is 14 reference to what the allegation was, that "A female 15 officer touches my bum and my dick and grabs me during 16 searches on visits". The initial note from the head of 17 safeguarding said, "I have some doubts as to the 18 credibility of the complaints, as both boys chose to 19 submit them on the same day", and there are various 20 other reasons why it was thought to be lacking in 21 credibility. 22 The LADO has said: 23 "I agree this invites some suspicion about the 24 genuineness of the allegation." 25 Then over the page, please:</p> <p style="text-align: center;">Page 132</p>

1 "An unidentified person had told Childline that he
 2 had been informed by a person recently released from
 3 Werrington that a 16-year-old had been raped while
 4 detained at Werrington by another inmate who was from
 5 a rival gang because of the young person's gang
 6 affiliation. The referral said inmates from other gangs
 7 and the young person's own gang were planning to target
 8 and assault the young person for informing on them."
 9 And an observation was made:
 10 "It is quite possible this is a malicious referral
 11 that needs putting to bed one way or another."
 12 **A. That's correct.**
 13 Q. That's the sort of thing that you felt exemplified this
 14 theme?
 15 **A. That's right, yes.**
 16 Q. Going back, please, to your report, the first report you
 17 produced on Werrington. You had also raised concerns,
 18 I think, about the lack of records in some areas. This
 19 is 2.1.12, so it's INQ001210, internal page 7, please.
 20 Scroll in on 2.12, please, I think it's a paragraph we
 21 have looked at before.
 22 **A. That's right, yes.**
 23 Q. Just help us a little bit with the detail on that,
 24 Mr Wood.
 25 **A. Again, this is the one where there was some issue**

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1 regarding why a record wasn't made about the entry into
 2 a child's cell, and there were some prior experiences of
 3 this young person being at high risk in particular
 4 areas. So I would have expected, if there was some
 5 pre-existing awareness of this child, that a very clear
 6 record of why the entry was made, who was there, what
 7 happened and what happened afterwards would have been
 8 there for me to look at, which wasn't there.
 9 **There's no context round that either, so there's no**
 10 **reason why that record wasn't made. It just says it's**
 11 **not clear why it was missing.**
 12 Q. I think if we can pull up, please, INQ001764_002 and
 13 scroll in, please, on paragraph 1.3, you confirmed again
 14 certain other examples of this lack of records in
 15 operation. Scroll in on 1.3, please, from NOM000009
 16 relating to those dates, 18 November 2011,
 17 18 March 2015, 24 February 2016, and 20 March 2016 were
 18 the Werrington examples, I think, of an absence of
 19 records --
 20 **A. That's right.**
 21 Q. -- that you'd have hoped to see?
 22 **A. Yes.**
 23 Q. You, I think, have made observations about the delay in
 24 responding to some allegations. Is that right?
 25 **A. That's correct, yes.**

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1 Q. And if we wish to see that, that's in your fifth report
 2 at paragraph 1.21, so that's INQ001764, internal page 5,
 3 please. Forgive me that's a bad reference, sorry, just
 4 bear with me a second.
 5 Forgive me, I will go back to the Werrington section
 6 at internal page 2, please.
 7 I think in this section you were asked to pick up
 8 several themes, perhaps deal with it in this way: 1.6 on
 9 this page, please, you raise some points about the
 10 nature of the investigation of some of the allegations
 11 at Werrington. What were the themes that you pulled out
 12 there, Mr Wood?
 13 **A. I think this is where the definition of what you mean by**
 14 **"internal investigation" comes in, as well, so there**
 15 **were examples whereby decisions were made for**
 16 **an internal investigation to happen and I think, for me,**
 17 **it would have been really helpful if it was explained**
 18 **about why that choice was made, what that meant, who**
 19 **would actually speak to the child, what the outcome of**
 20 **the investigation was, what the issues were, what the**
 21 **potential was as well, and what would also happen if the**
 22 **internal investigation highlighted that it was needed to**
 23 **be externally examined as well. Those things weren't**
 24 **there, so I think in terms of the choice made in terms**
 25 **of which route to go down, I think sometimes, for me --**

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1 **the LADO perspective as well, there is an issue into, if**
 2 **the LADO says there is no need or there's no requirement**
 3 **for investigation to go through that route, then it's**
 4 **pushed back then in terms of the institution to complete**
 5 **their own internal investigation at that point.**
 6 **I suppose, for me, the loop then has slightly got**
 7 **a gap in it, really, in terms of what happens then as**
 8 **investigation highlights any other issues?**
 9 Q. Perhaps we can go, please, to internal page 9 in that
 10 report so it's INQ001764, internal page 9. At the foot
 11 of the page, you were asked about some specific
 12 allegations and how they're investigated. Perhaps the
 13 panel can just scroll in on 1.45 and the following page.
 14 I think for each of these -- and there are, I think,
 15 five or six different dates, so it's 1.45 through to
 16 1.51, perhaps the panel can just scroll in on that --
 17 you fleshed out why you felt there had been a lack of
 18 full investigation for some of these issues. Is that
 19 right?
 20 **A. That's right, yes.**
 21 Q. So you picked out, for example, themes where -- 1.46 by
 22 way of example:
 23 "8 April 2013, CCTV was used in the area where
 24 searches took place. Two members of staff were present.
 25 There is no record of the CCTV being checked and that

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<p>1 anyone else present during the search was questioned. 2 The boys appeared to withdraw the allegation once 3 an explanation was given to them in regard to the 4 thorough manner the member of staff concerned undertook 5 the searches. There is a relationship here between the 6 experience of a child in relation to how any allegations 7 are received and managed and communicated about and the 8 likelihood of retraction, given a lack of trust and 9 confidence." 10 There are various other points of detail that you 11 take the panel to in relation to other allegations but 12 of a similar sort of concern. Is that right? 13 A. That's right. 14 Q. Just bear with me a second, to see whether I need to 15 bring this one up. I think a related point, perhaps, is 16 at 2.1.11 of your first report. That's INQ0001216_007 17 at 2.1.11, I think as well as a concern about 18 qualitative investigative steps, if you like. There was 19 a concern at 2.1.11 about contact with members of staff 20 once allegations had been made against them. Is that 21 right? 22 A. Yes, that is right, yes. 23 Q. Just help us a bit with what you said about that, 24 please -- sorry, it's INQ0001216 -- is it? Or is it my 25 handwriting? Is it 1210? That's why you can't find it,</p> <p style="text-align: center;">Page 137</p>	<p>1 denying the attack actually happened, I think the way in 2 which he responded to the information being shared with 3 him did raise some concern for me. 4 I think also it would have been helpful, I think, if 5 the record indicated an awareness of the fact that there 6 could be a relationship between the state of the young 7 person, the risks he was experiencing, the control and 8 also the shame element and the power of gangs in terms 9 of controlling children and young people. 10 I suppose, for me, the other issue was that, I mean, 11 I appreciate completely if a young person is saying, 12 "No, it didn't happen and the allegation is completely 13 untrue", and it's not appropriate to go back over and 14 over again the same issue. What would have been 15 helpful, I think, is, given the context of the gang -- 16 and the information's quite detailed from the outside in 17 terms of this issue -- it would have been quite helpful 18 to record at least that young the person's given the 19 opportunity to come back to the issue if he wanted to or 20 if there is some information to be shared with him about 21 the impact of gangs upon people and how to recognise the 22 signs of control and that. 23 So I accept that the young person said it didn't 24 happen. However, I think it would have been helpful, 25 given the context and the height and risk around these</p> <p style="text-align: center;">Page 139</p>
<p>1 sorry. 1210_007. It's 2.1.11, please: what was the 2 issue that you identified there about contact with 3 children and the staff member in question? 4 A. That was the issue really, I suppose. When a child's 5 made an allegation against a particular member of staff, 6 to be clear about what would happen and how they're 7 going to try to manage the issue, that member of staff 8 may come into contact with that child, where the member 9 of staff has moved to a different unit or whatever, but 10 I think for me there wasn't much evidence on this one in 11 particular in terms of how they're going to try to work 12 with that risk. So from a child's point of view -- 13 I mean, the member of staff could obviously be told not 14 to discuss anything about the allegation which has been 15 made, but from the child's experience, to see that same 16 member of staff would be difficult. 17 Q. Then if we just scroll down on that page, please, to 18 2.1.16, I think we deal here with this particular 19 allegation which I think is an allegation that a 16-year 20 old boy had been raped by another detainee in the 21 context of a gang -- 22 A. That's right, yes. 23 Q. -- situation. What was your concern about that 24 particular allegation and its response? 25 A. Whilst I accept that the young person was completely</p> <p style="text-align: center;">Page 138</p>	<p>1 issues, that the door would have been kept for him to 2 push it and to then talk to a member of staff after the 3 incident. 4 Q. I think more generally, if I can take you, please, to 5 INQ0001764, internal page 2, please, and scroll it on to 6 paragraphs 1.5 and 6. I think you have made the point 7 that there is a need for staff to be trained in how to 8 work directly with children in terms of responding to 9 their allegations in a way that doesn't then impact upon 10 any potential criminal or civil proceedings, so what's 11 your point there about that, Mr Wood? 12 A. I think in terms of the likely range of experience, 13 skills and attitude of staff members working in any 14 institution, it's important to think that people are 15 given tips and techniques about how to respond when 16 a child does actually explicitly say something's going 17 wrong in terms of an allegation or the more tricky one, 18 I suppose, is in terms of children starting to drop 19 hints around issues, behaviour starting to change, their 20 relationship with other people starting to change. So 21 it's being open to the idea of things, which is 22 a difficult one for institutions to accept that sexual 23 abuse can happen here and sex abusers look like 24 everybody here. So I suppose, for me, there's quite 25 a big leap in terms of institutions accepting the fact</p> <p style="text-align: center;">Page 140</p>

<p>1 that there is an inherent risk, when you get adults and 2 children together, that some people are purposely trying 3 to gain access to children and young people. So how you 4 respond to that is important and how you respond to 5 children and young people in the absence of allegations 6 is important as well because that sets the context for 7 your relationship with them. 8 And I think the recent developments from other young 9 offender institutions whereby the relationship practice 10 angle is starting to be built up, that's really good to 11 hear because that's the basis of children feeling 12 confident that allegations will be taken in a serious 13 way. 14 It also creates -- I think from a staff training 15 point of view, it creates the atmosphere and the 16 approach in the unit whereby allegations are less likely 17 to happen because abuse is less likely to happen. So 18 there's a relationship between those two things. 19 Q. Then finally a few points, please, about the role of the 20 local authority here, 1.38, please, of your fifth 21 report, so if we can go, please, to INQ001764, internal 22 page 7, to your fifth report and scroll in, please, on 23 1.38 at the bottom. 24 Just to anchor this, Mr Wood you were asked here 25 about the procedures as set out in the London Child</p> <p style="text-align: center;">Page 141</p>	<p>1 the LADO did not attend. The outcome was 2 unsubstantiated. There was no explanation as to the 3 reason for the LADO's absence or if the LADO's views had 4 been sought in relation to the outcome. In my opinion 5 the absence of the LADO was grounds for the meeting to 6 be suspended until the LADO was available." 7 And then the third example you give: 8 "An alleged sexual assault by a member of staff 9 during restraint within a cell was not referred to the 10 LADO or Social Services. The key driver appears to be 11 the deputy governor was present during the restraint and 12 the young person had said he was naked, whereas he was 13 wearing boxer shorts. In my opinion, there were grounds 14 to refer this alleged sexual assault to the LADO." 15 A. That's right, yes. 16 Q. You've, I think, repeated here in this part of your 17 report the evidence you gave earlier today about how you 18 consider the default position should be that 19 a section 47 inquiry is undertaken in relation to 20 a child in custody. Is there anything further in the 21 context of Werrington you want to say about that? 22 A. I suppose, as a generic comment, that I think it would 23 be helpful, given the additional needs of children and 24 young people who are in custody, that we talked about 25 earlier last week and also earlier today, that the</p> <p style="text-align: center;">Page 143</p>
<p>1 Protection Procedures and so on for responding to 2 allegations and you say at 1.38 that these are some 3 examples where you feel the fact that the victim was in 4 custody may have influenced how that allegation was 5 responded to compared to had they been in the community. 6 Is that right? 7 A. That's right, yes. 8 Q. We can take the panel through here, under (a) in 9 relation to Werrington: 10 "An alleged physical and sexual assault and 11 associated threats of violence were reported to 12 Social Services but were then deemed not seriously 13 enough to reach the threshold for investigation." 14 It appears that the separation into two single cells 15 of the two boys concerned was perceived as a sufficient 16 response and reminding the victim of his right to 17 contact the police: 18 "In my opinion, the behaviour of the alleged 19 perpetrator would have warranted action linked to the 20 need to assess sexually harmful behaviour and, as such, 21 the needs of the victim and perpetrator should have been 22 assessed as part of a multi-agency plan." 23 Under (b): 24 "An alleged sexual assault by a member of staff 25 during a search was referred for a strategy meeting but</p> <p style="text-align: center;">Page 142</p>	<p>1 starting point should be that and then a clear 2 explanation about why that is not the right route to be 3 written down. 4 Q. Then, just for completeness, over the page, please, 5 internal page 9 at the top of that page, you have 6 confirmed from your analysis of the Werrington material 7 that none of the allegations were substantiated. 8 A small minority had substantive police investigations 9 but none were subjected to section 47 investigations. 10 Is that right? 11 A. That's what I understand from the record, yes. 12 Q. Is there anything else about the Werrington material 13 that you feel I need to pull out to assist the chair and 14 panel, Mr Wood? 15 A. Just a generic view. I think, also, just in terms of 16 the London Child Protection Procedures, I think it's 17 3.3.2 in those, it does give a very clear definition of 18 when section 47 should actually happen and which then 19 aligns to my earlier point in terms of that being the 20 default position and working backwards from that, so 21 it's useful, I think, just to remind yourselves of that, 22 actually. It is quite clearly defined in terms of 23 a suspicion or allegation against an adult, so that's -- 24 Q. I think the theme that you have identified is that they 25 didn't seem to be happening enough across these two</p> <p style="text-align: center;">Page 144</p>

<p>1 institutions at least. Is that right?</p> <p>2 A. Yes, that is right. I think one of the other issues, as</p> <p>3 I said before earlier today, is that explanations,</p> <p>4 records, connections, cross-referencing may be evident</p> <p>5 elsewhere, but it wasn't that clear in the records</p> <p>6 I looked at.</p> <p>7 MS HILL: Chair, I'm not sure if you have any questions for</p> <p>8 Mr Wood on the Werrington paperwork?</p> <p>9 THE CHAIR: No, thank you. Thank you very much.</p> <p>10 MS HILL: Chair, that might be a moment to take our break</p> <p>11 and we have one more witness after the break.</p> <p>12 THE CHAIR: Yes, we will return at 3.20.</p> <p>13 (3.07 pm)</p> <p>14 (A short break)</p> <p>15 (3.20 pm)</p> <p>16 MS HILL: Thank you, chair. I will call, please,</p> <p>17 Peter Gormley.</p> <p>18 MR PETER GORMLEY (sworn)</p> <p>19 Examination by MS HILL</p> <p>20 MS HILL: Thank you very much. You're Peter Gormley; is</p> <p>21 that right?</p> <p>22 A. That's correct.</p> <p>23 Q. You were governor at Werrington -- again, is this</p> <p>24 right? -- until April of 2018?</p> <p>25 A. Yes, that is correct.</p> <p style="text-align: center;">Page 145</p>	<p>1 A. They are, yes.</p> <p>2 Q. You have a dedicated social worker and a dedicated</p> <p>3 senior social worker employed through the</p> <p>4 local authority, and you say this at paragraph 7 of your</p> <p>5 statement:</p> <p>6 "They are in place to provide external scrutiny to</p> <p>7 the Child Protection Procedures and ensure that all</p> <p>8 looked after children are supported throughout their</p> <p>9 time in custody. All young people arriving into</p> <p>10 Werrington meet with their dedicated social worker</p> <p>11 on-site."</p> <p>12 A. That's correct.</p> <p>13 Q. Looked-after children are obviously children who are</p> <p>14 coming into care in that category. That's not all the</p> <p>15 children in care, is it?</p> <p>16 A. No, it's not, but children that come in on remand are</p> <p>17 considered to take on looked-after status, so a fairly</p> <p>18 large proportion are.</p> <p>19 Q. So those children will automatically meet a social</p> <p>20 worker, but children who are sentenced won't</p> <p>21 automatically be seen as looked after. Is that correct?</p> <p>22 A. That's correct. They will -- the social workers form</p> <p>23 part of our induction, so the child's induction into the</p> <p>24 establishment, so the social workers will form part of</p> <p>25 that. So they will meet them.</p> <p style="text-align: center;">Page 147</p>
<p>1 Q. So again, rather like your colleague, Mr Gormley, you're</p> <p>2 here to give the panel some broad evidence about the</p> <p>3 systems in place at Werrington in terms of child</p> <p>4 protection and sexual abuse issues, but also to provide</p> <p>5 some response to Mr Wood's evidence. Is that correct?</p> <p>6 A. Yes.</p> <p>7 Q. Help us a little bit, please, with some background then</p> <p>8 about Werrington?</p> <p>9 A. So Werrington is one of the public sector young</p> <p>10 offenders' institutes. It's one of the smaller ones.</p> <p>11 We lock up 118 or we care for 118 children, maximum.</p> <p>12 Q. I think I have read about 110. Is that right?</p> <p>13 A. On average 110, we can go up to 118. There are three</p> <p>14 main units, which is residential units in the</p> <p>15 establishment, two of which, A and B wing we call normal</p> <p>16 units and the third one, C wing, which is our care and</p> <p>17 separation unit and also offers an induction with</p> <p>18 an element of enhanced provision for children that are</p> <p>19 on gold regimes.</p> <p>20 Q. A care and support unit in C wing has eight cells for</p> <p>21 segregation for people away from the main wings; is that</p> <p>22 right?</p> <p>23 A. Yes, it does.</p> <p>24 Q. All of the young people are housed in single cells</p> <p>25 across all the wings; is that right?</p> <p style="text-align: center;">Page 146</p>	<p>1 Q. So all children will be made aware of the presence of</p> <p>2 the social workers; is that correct?</p> <p>3 A. Yes.</p> <p>4 Q. Forgive me, Mr Gormley I should have formally adduced</p> <p>5 your witness statement of 13 July HMP000405, with your</p> <p>6 permission, chair.</p> <p>7 You were asked some questions about</p> <p>8 the February 2017 report on Werrington, especially</p> <p>9 around the safety and safeguarding findings, and you, I</p> <p>10 think, have, rather similarly to your colleague, pointed</p> <p>11 out that there is a more recent report from earlier this</p> <p>12 year that is more favourable. Is that right?</p> <p>13 A. In terms of safety, it's a similar score, it's the</p> <p>14 same -- it hasn't gone up or down.</p> <p>15 Q. Let's perhaps just bring up the details, if we may.</p> <p>16 Let's go first to the 2017 report at INQ001457_001.</p> <p>17 Perhaps let's go within that to the introductory</p> <p>18 narrative, please, on internal page 5. This is</p> <p>19 your May 2017 report, we will just perhaps scroll</p> <p>20 through it. It makes the point that there was by this</p> <p>21 point in the third paragraph -- well, in fact, let's go</p> <p>22 to the first paragraph -- that at the previous report</p> <p>23 in October 2015 there were concerns about the safety at</p> <p>24 Werrington, although in all other respects outcomes were</p> <p>25 reasonably good or better:</p> <p style="text-align: center;">Page 148</p>

<p>1 "We indicated our confidence then that the 2 management team would improve outcomes in safety." 3 And the third paragraph makes clear that by this 4 point there had been an improvement in the children's 5 perception of safety. It was clear that managers and 6 staff were working hard to reduce violence which was 7 evidencing some success. 8 And there were various other observations made. 9 Some points, for example, about access to telephones 10 being limited and that causing some friction. Time out 11 of cells for boys was reasonable. Ofsted assessed the 12 overall provision as good. I think the conclusion on 13 this page was that, "Werrington, like other young 14 offenders' institutions, faces some tough challenges and 15 works with boys who can be very difficult, but it 16 continues to do well. It was well-led with coherent 17 innovative plans and initiatives helping to create 18 a much more positive ethos in the institution than we 19 see elsewhere. The priorities for Werrington include 20 further reductions in violence and work to sustain the 21 resilience of the staff group so that they can build 22 upon the progress they have made." 23 Just bear with me a second. 24 I think if we can go then to your exhibit PG1 which 25 is at HMP000406 and go to the second internal page of</p> <p style="text-align: center;">Page 149</p>	<p>1 tackle the violence and early indications were that they 2 were having a positive effect. The ambition was to make 3 the YOI safer but not at the expense of the regime. 4 These efforts are detailed in this report." 5 If we go to the very top of that page, 6 in January 2018 it says: 7 "We found not only that standards had been 8 maintained. In the area of respect they had improved 9 and now merited our highest assessment of 'good'. By 10 any standards, this was a good inspection." 11 So although that was there ongoing concern about 12 safety and in fact that element having got worse or 13 levels of violence having risen and use of force being 14 high, overall this was a positive inspection. Is there 15 anything else that you would like to add on that, 16 Mr Gormley? You have given some evidence at 17 paragraphs 8 to 12 of your witness statement. Is there 18 anything else that you would like to say? 19 A. Only that I think it's proven that if you take the 20 inspection and the recommendation serious and the 21 resources are put towards what can be achieved in 22 a young offenders' institution, then clearly the 23 outcomes for the children that are being cared for are 24 better. 25 Q. Let's scroll in, in fact, on your report, please, at</p> <p style="text-align: center;">Page 151</p>
<p>1 that, please, we will see that this is the much more -- 2 well, a more recent report from earlier this year, and 3 if we go, please, to the March 2018 introduction on 4 page 5 internally, and one can see -- just go to the 5 last paragraph, please, on that page: 6 "In conclusion, it is pleasing to be able to publish 7 a very positive report about a YOI. The inspectorate 8 always welcomes good practice being identified and 9 promulgated, which is why we have gone to particular 10 lengths in this report to do so. It is clear that if 11 progress that has been made at Werrington is to be 12 consolidated and maintained, there needs to be 13 a continued and unwavering focus on reducing the 14 violence that is the major threat to its continuing 15 stability and success." 16 If we go further up in that narrative to the third 17 paragraph, there was a concern, it says: 18 "Our major concerns were around the levels of 19 violence which had risen since the last inspection and 20 were too high. There had been a significant increase 21 from 142 to 206 incidents in the period leading up to 22 this inspection. There had been an increase in the use 23 of force and, in light of this, it was disappointing 24 that body-worn video cameras were underused. 25 Nevertheless, there were good initiatives in place to</p> <p style="text-align: center;">Page 150</p>	<p>1 your statement, please, HMP000405 internal page 3, 2 paragraph 10, please -- 10 and 11, sorry, 10 and 11. 3 You quote part of the report here and you say, I think, 4 that this is the particular part that you think the 5 panel might want to look at, that boys were positive 6 about their early days at Werrington. Safeguarding and 7 child protection arrangements were good. Support for 8 boys at risk of self-harm was also good, although there 9 was that concern about the use of violence. The outcome 10 at the end of this paragraph: 11 "Outcomes of children and young people were 12 reasonably good against this healthy prison test." 13 And that's the safety test, I think, isn't it? 14 A. That's correct. 15 Q. All right. You accept, I think, at paragraph 12 that 16 efforts are required to reduce the level of violence in 17 the establishment but that overall that was a positive 18 inspection. 19 A. Yes, that is correct. 20 Q. Now, you've provided some observations in response to 21 Mr Wood's evidence. Help us with what broad themes you 22 want to draw out from the examination that he carried 23 out. I think, obviously, he's looked at ten incidents 24 over a 7-year period, so what's the broad point that you 25 make about that?</p> <p style="text-align: center;">Page 152</p>

<p>1 A. Just the fact that is a very small sample size, I think. 2 And particularly the issue around the complaint forms 3 not being specifically for complaining or disclosing 4 sexual abuse. 5 Q. Taking those in two parts, if I may. You make the 6 point, I think, at paragraph 14 of your witness 7 statement that seven years is a long time in the life of 8 an establishment. 9 A. Yes. 10 Q. And I think the latest HMIP report that we have gone to 11 you say is perhaps more helpful for the panel to look at 12 in a broad sense. Is that right? 13 A. Yes, yes. 14 Q. But you note that he has observed that Werrington 15 generally had responded in a timely and structurally 16 appropriate way, which you welcome. 17 A. Yes. 18 Q. What's your view on the issue of the complaint forms 19 that Mr Wood has raised, Mr Gormley? Help us with that. 20 A. I can completely understand Mr Wood's thoughts around 21 the complaint procedure, but it is a generic complaint 22 form for a number of reasons. It is, as I've pointed 23 out in my statement, out of the ten sample size, only 24 two of them, of the incidents, were actually reported by 25 the complaints form, so it demonstrates to me that there</p> <p style="text-align: center;">Page 153</p>	<p>1 weren't discouraged by the form being structured in 2 a certain, perhaps more complicated, way. 3 Help us, then, with what other routes are available 4 at Werrington for the children to make disclosures if 5 they wish. 6 A. So simply by talking to a member of staff, any member of 7 staff. There are lots of independent people who work at 8 Werrington. So, for example, there are youth workers, 9 Kinetic Youth workers. 10 Q. That's Kinetic Youth workers, isn't it? 11 A. Kinetic, yes. There is advocacy service, which is 12 Barnardo's. There is the independent monitoring board, 13 then there is the social workers who are local authority 14 social workers, so there is a whole range of staff they 15 can talk to, or independent people. 16 Q. And you have CuSP officers I think already in place, is 17 that right, at Werrington? 18 A. We do, yes. So that's like a personal officer to -- so 19 the -- they will be identified for a number of children 20 that they personally take, look after and meet with them 21 once a week. They can certainly disclose anything to 22 those members of staff and then there is the phone 23 lines, ChildLine, the ... 24 Q. NSPCC line -- 25 A. NSPCC, sorry, yes.</p> <p style="text-align: center;">Page 155</p>
<p>1 are a number of ways that a child can disclose 2 information, not just using this complaints form. 3 I do have concerns that if we make a specific form 4 for declaring abuse that may not be used, because I do 5 think that some children don't understand what they're 6 declaring. 7 I think the system that we've got at the moment with 8 safeguarding trained staff who will look at a complaint 9 and if there is an allegation of or a potential abuse 10 element within that complaint then we process it well, 11 because ultimately all those complaints then go to the 12 safeguarding department where social workers and 13 safeguarding staff will look at that complaint. 14 Q. So in fact you share the concerns expressed by the 15 Feltham governor, is that right, that if there was 16 a special box on the form for sexual abuse you would be 17 concerned that that might miss some allegations because 18 children might not know how to define it to put it in 19 that box; is that one of the issues that you're talking 20 about? 21 A. That is a potential, yes. Yes. 22 Q. And I think you say that you don't want the form to 23 become too complex, you try and keep it as simple and 24 straightforward as possible, because it's a generic 25 form. You would be anxious to ensure that children</p> <p style="text-align: center;">Page 154</p>	<p>1 Q. -- and as with other institutions there is always 2 availability of COMP 2, which is a confidential 3 complaint to the governor. Is that right? 4 A. Yes, that's a standard form, the confidential complaints 5 form. 6 Q. There's a chaplain, I think, as well? 7 A. Yes. 8 Q. And is this right: you've also explained that third 9 parties who have observed changes in behaviour on the 10 part of a child, or who have witnessed conduct which 11 they consider to be inappropriate, or that's been 12 reported by a family member could also come into the 13 safeguarding route? 14 A. Yes, they can, the important thing for me is that 15 whichever method of disclosure or potential disclosure 16 takes place, it always goes to the safeguarding for 17 a child protection referral where staff there, 18 multi-disciplined staff will -- I call it triaging, 19 where they would look at what the evidence or the 20 submission states and then they'll take appropriate 21 action. 22 Q. Dealing with the issue of the support that's given to 23 children after disclosure of abuse is made, have you 24 made the point, as others have, that perhaps Mr Wood has 25 looked at the core documentation but there may be</p> <p style="text-align: center;">Page 156</p>

1 evidence in other material of support being provided to
 2 the children?
 3 **A. Yes, so for example at Werrington, one of the main**
 4 **support mechanisms is that any child who makes**
 5 **an allegation will be seen by the embedded social**
 6 **workers. That social worker will stay with that child**
 7 **in terms of support until such time that the**
 8 **investigation or whatever the outcome is concluded.**
 9 Q. I think you go on, in fact, at paragraph 24 of your
 10 witness statement and say that in addition to the
 11 involvement of the dedicated social worker, every child
 12 making an allegation is seen by the duty governor and/or
 13 the orderly officer depending on the time of day you
 14 will conduct an initial assessment of the needs of the
 15 child, including any vulnerability that may arise from
 16 the making of the allegation and the need for immediate
 17 steps are to be taken, such as enhanced observations or
 18 a move to a different part of the establishment.
 19 Have we understood that correctly, then, that what
 20 you're saying is that every child who discloses sexual
 21 abuse will be seen by the duty governor; is that what
 22 you are saying at 24 of your statement?
 23 **A. Yes, so if a serious allegation is made then the duty**
 24 **governor or the orderly officer, which is another one of**
 25 **the managers in the establishment, will go to see that**

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1 **child because the overriding concern is obviously**
 2 **safeguarding and to see if there is anything that needs**
 3 **to be done immediately.**
 4 Q. Do you think there is any risk that that process, which
 5 involves the child being seen by a very senior figure in
 6 the prison, might make the child concerned about
 7 reprisals or might make it obvious that something
 8 serious has happened?
 9 **A. There is always a risk, of course, of that, but one**
 10 **thing that it demonstrates, I believe, to the child, is**
 11 **that it would take is seriously.**
 12 Q. I see, so you balance the two --
 13 **A. Yes.**
 14 Q. -- and you think in balance it's struck the other way?
 15 **A. Yes.**
 16 Q. The dialogue with the local authority that is now in
 17 place at Werrington, please help the panel with that
 18 topic.
 19 **A. So if an allegation is brought to the attention of the**
 20 **safeguarding department then, as I said, triage will**
 21 **take place through one of the social workers or maybe**
 22 **even both if they're available, a senior member of the**
 23 **management team and some of the safeguarding team, to**
 24 **decide what they will do with that allegation.**
 25 **Clearly they will be in touch with the**

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1 **local authority to have some dialogue to say whether**
 2 **they think it meets the threshold for a strategy**
 3 **meeting, section 47, and then they will task appropriate**
 4 **action from that dialogue.**
 5 Q. Is there anything else about the work with the
 6 local authority that you wish to draw to the panel's
 7 attention?
 8 **A. Yes, the local authority independently scrutinise**
 9 **incidents at Werrington. So, for example, under use of**
 10 **force, they will sit on a quarterly board meeting where**
 11 **they actually chair the meeting and they have access to**
 12 **view all incidents and/or paperwork and will review it**
 13 **and make recommendations to us about what we can do to**
 14 **improve, or if there are any concerns about a particular**
 15 **incident. They also do that for the child protection**
 16 **logs, as well, at the monthly safeguarding meeting.**
 17 Q. And what would happen if you had concerns about the
 18 LADO's assessment? So let's just say the LADO said that
 19 the case did not meet the threshold for a strategy
 20 meeting. What would happen then?
 21 **A. You mean if I have concerns that I thought it did?**
 22 Q. No, if you disagreed with the LADO's assessment.
 23 **A. Ultimately it's the LADO's decision but we will**
 24 **certainly have that conversation and, you know, they are**
 25 **quite challenging meetings where what I would call**

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1 **professional tension is -- for me, actually, it's**
 2 **a necessity because that gives me the reassurance that**
 3 **actually staff are challenging and accepting -- not just**
 4 **accepting what, you know, one of the agencies say. They**
 5 **are multi-agencies so there are lots of opinion that**
 6 **make that decision -- lots of people, sorry, that make**
 7 **that decision.**
 8 Q. You say you have attempted to establish an environment
 9 which encourages a frank exchange of views between the
 10 professionals involved:
 11 "It's not uncommon for there to be debate about the
 12 correct course of action, but as governor I find this to
 13 be reassuring, gives me confidence that we end up with
 14 the right course of action in each case."
 15 Is that what you have said here?
 16 **A. Yes.**
 17 Q. As you know, one of the themes has been that Mr Wood has
 18 drawn out this concern about suspicion as opposed to
 19 validity. What do you wish to say about that,
 20 Mr Gormley?
 21 **A. I mean, the one incident that Mr Wood has pointed out is**
 22 **clearly that is an interpretation of that. What I would**
 23 **say in terms of reassurance is the fact that whatever**
 24 **the initial response is, the same process is followed in**
 25 **terms of the independent rigour that that is**

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<p>1 investigated with and they are always done via 2 a multi-disciplinary meeting, so whilst the words there, 3 I can accept that that is the case on that one example. 4 Q. I think you say this: that there may well have been 5 variability of practice in the observation in the period 6 of time that Mr Wood was looking at. You're conscious 7 of the need to keep staff aware of the importance of 8 approaching complaints with an open mind and recording 9 them in a neutral and objective way. And I think two 10 further points you say you're not aware of any 11 widespread deficiency in this regard at the moment, 12 never flagged in the HMIP inspection and safeguarding 13 department or the IMB haven't raised it either, so 14 you're hopeful that that's not part of a wider problem 15 now. Is that right? 16 A. That's correct, yes. 17 Q. The safeguarding department you say will consider every 18 allegation in a rigorous and objective manner without 19 any pre-judgment. Inevitably you do need to look at the 20 complaints history of the child to some degree but you 21 say: 22 "I assure the inquiry that the safeguarding 23 department considers each allegation on its merits and 24 without any pre-conception as to its validity." 25 Is that fair?</p> <p style="text-align: center;">Page 161</p>	<p>1 about the position now? 2 A. Clearly records are -- have gone missing. That is 3 a fault, as is the response in terms of the tone is 4 a training issue. I believe that records are far more 5 rigorous now. They are quality assured on a monthly 6 basis and they are signed off by the governor of the 7 establishment at the end of it, so I would say now we're 8 in a much stronger position in terms of record keeping. 9 Q. How would you respond to the points he has made about 10 the allegation in relation to gangs? So that was 11 an allegation about sexual abuse in the context of gang 12 membership and I think the suggestion was there appeared 13 to be a lack of understanding of that context at 14 Werrington. What do you say about that? 15 A. I don't think there is a lack of understanding of gangs. 16 You know, we work with a lot of gang issues at 17 Werrington, as well as all other establishments. 18 Q. I think you go on to say that gang membership may just 19 be one of many reasons why a child might be reluctant to 20 disclose. 21 A. Indeed, yes. 22 Q. And a difficult case involving rival gangs may well 23 involve a range of strategies. We would hope that over 24 time and with encouragement a child would be prepared to 25 voice his concerns, but ultimately if a child is adamant</p> <p style="text-align: center;">Page 163</p>
<p>1 A. That's correct. 2 Q. And what is your response to the observations he has 3 made about the concerns regarding aggression and 4 violence on the part of the children appear to have 5 framed the focus. What do you say about that? 6 A. The -- the one incident that was given, obviously it's 7 concerning and staff should be able to respond in 8 a manner which is appropriate to the child. Clearly, 9 this one case I would have thought would have given rise 10 for concern that if a child was responding in 11 an aggressive manner more generally. 12 Q. I think you said that if staff are unduly distracted by 13 the child's behaviour rather than subsequent complaint 14 then that is a concern, but you have not had this wider 15 concern brought to your attention by the safeguarding 16 department or the local authority. Is that right? 17 A. That's correct. 18 Q. And in relation to the absence of records, help us with 19 what you say about that. I think paragraph 36 of your 20 witness statement, if it helps you, you say that I think 21 you would accept that there clearly has been a record 22 keeping failure in relation to some of the areas Mr Wood 23 identifies. You go on to say you're not clear why in 24 a particular case records have not been kept. You 25 accept that they should have been and what do you say</p> <p style="text-align: center;">Page 162</p>	<p>1 in his denial that he's been abused then you're simply 2 unable to take the matter forward. Is that right? 3 A. That's correct, but the important thing for me is that 4 we make sure we keep the door open for that child and at 5 some point if they feel safe enough they will disclose 6 something further. 7 Q. Having reflected as you have, Mr Gormley, on the issues 8 that we have been through with you, is there anything 9 else that you think Werrington can do to improve its 10 systems to protect children from sexual abuse or to 11 respond better when it happens? 12 A. Certainly in terms of resources, staffing resource, we 13 now, as a youth custody service, attract and recruit 14 specifically to members of staff who are going to work 15 with children, which is important. The training element 16 is also equally important. We do safeguarding initial 17 training and follow-up safeguarding training and we are 18 just introducing through reform and in part in response 19 to the Taylor Report, we are introducing a youth justice 20 foundation degree, which has elements of safeguarding in 21 it and the good thing for that for me is that we are 22 also in a position where we can refine and amend that 23 delivery or that foundation degree, and our ambition is 24 to have 100 per cent frontline staff trained in that. 25 So --</p> <p style="text-align: center;">Page 164</p>

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

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

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

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1 THE CHAIR: Mr Frank.
 2 MR FRANK: I think in fairness to you, in your witness
 3 statement, which is dated 13 July, so, what, last
 4 Friday, was it? You indicate that you have not
 5 yourself, you say, had an opportunity to investigate the
 6 alleged incidents that have been referred to by
 7 Mr Wood's report in detail. I think that's the way you
 8 put it.
 9 **A. That's right.**
 10 MR FRANK: But you're familiar with the contents of the
 11 report and the broad thrust of the incidents that he
 12 brought to our attention.
 13 **A. Yes, I am.**
 14 MR FRANK: You see, it may be right that you say that there
 15 were only ten alleged incidents over a period of
 16 five years and you say they may not be representative,
 17 but from the point of view of the child who makes the
 18 complaint, if they feel it has not been fairly
 19 investigated it's the only incident they need to know
 20 about to put them off making any further complaints in
 21 future if they have not been fairly dealt with.
 22 So what I want to ask you is this: in respect of --
 23 and we can put this up on the screen, please --
 24 INQ001764_009, which refers to an incident on
 25 24 February 2016, so not that long ago, we see there is

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<p>1 an incident where a written statement from the deputy 2 governor who witnessed the alleged assault was not 3 actually present on the file, it would appear. Can you 4 help about that? 5 A. I can't, unfortunately, no. I have no knowledge of 6 that. 7 MR FRANK: No evidence of a questioning of the deputy 8 governor or of any other members who were present at the 9 time of that assault; any idea about that? 10 A. I haven't. 11 MR FRANK: Do you think that's good practice? 12 A. No, it's not. 13 MR FRANK: Again, when we look at 1.47, in relation to there 14 being no CCTV evidence, whereas the allegation took 15 place in the child's cell where there would be no CCTV. 16 Was that a proper reason for not furthering the 17 investigation, the fact that there wasn't a CCTV record 18 where you wouldn't expect one? 19 A. No. 20 MR FRANK: No and, again, if we look further down, 1.51, 21 linked allegation, the fact that CCTV does not cover the 22 young person's cell appears not to have been taken into 23 account. Does that appear to you to be a proper 24 response to that investigation? 25 A. No, it doesn't.</p> <p style="text-align: center;">Page 169</p>	<p>1 I'm afraid, have time to read in, because it is, 2 perhaps, pertinent for you to be aware of this and have 3 this in mind. 4 So, chair, we had hoped to read in some evidence 5 from the independent monitoring board from Saffron 6 Clackson in statements dated 20 May 2016 and Rachel 7 Stuart, 3 July 2018, in IMB000001 and IMB000008, where 8 they set out the role of the independent monitoring 9 board in terms of visiting institutions and where they 10 set out the number of complaints that had been made to 11 that institution of sexual abuse. 12 Similarly, chair, we have also asked you to have 13 regard, please, to evidence from the Prison and 14 Probations Ombudsman. That's a statement, or a letter 15 from Nigel Newcomen, dated 9 September 2016 at PPO000001 16 and information also from Elizabeth Moody, dated 17 10 April PPO000003, which again sets out the role they 18 perform and the number of allegations they had had 19 reported to them. 20 Finally in this group, please, there is a statement 21 from the Children's Commissioner, Anne Longfield, dated 22 12 April 2018, INQ001175, and, again, confirming the 23 role performed by the Children's Commissioner and 24 confirming that they had received no disclosures of 25 sexual abuse.</p> <p style="text-align: center;">Page 171</p>
<p>1 MR FRANK: No. 2 Yes, thank you, that's all I ask. 3 THE CHAIR: Thank you very much, Mr Gormley. 4 MS HILL: Thank you, Mr Gormley. 5 Chair, just in the remaining few minutes -- 6 Mr Gormley can leave the witness box, thank you very 7 much -- we have a short statement from Yvonne Gordon 8 just to adduce this formally, please. Just by way of 9 clarification, as I'm sure you've appreciated, chair, 10 for each of the institutions there is a local authority 11 that sits alongside that. 12 In relation to this particular local authority, 13 Staffordshire County Council, Mr Wood confirmed in 14 a report of 13 June at INQ001255 that there was no 15 criticism of Staffordshire County Council in relation to 16 their conduct on those allegations, so I will formally 17 adduce, if I may please, just simply a statement from 18 Yvonne Gordon that sets out the general systems in place 19 as far as Staffordshire are concerned, and Werrington. 20 That's a statement dated 16 February 2018, SFC000023 and 21 the whole of that statement, chair, sets out their 22 safeguarding processes in outline. 23 Chair, I wonder if I might just take the last 24 few minutes just formally to adduce some material that 25 we had hoped to read in last week that we didn't,</p> <p style="text-align: center;">Page 170</p>	<p>1 And then finally, please, we would ask you to have 2 regard to material from Rosamund Roughton of 3 NHS England, who has given a lengthy statement dated 4 28 November 2016, NHS000027, which sets out an overview 5 of the role of the NHS as far as children in custody are 6 concerned, includes information, for example, about the 7 CHAT assessment tool, the comprehensive health 8 assessment tool, about which you have heard, and 9 includes further detail that we would ask you to 10 consider. 11 And there is finally evidence from Nadine Good, 12 assistant director at Barnardo's, dated 5 June 2018 in 13 BRD000238, the pertinence, perhaps, of that material, 14 chair, is that it goes to give you an understanding of 15 the advocacy services Barnardo's provided, the 16 information given to the children about those services. 17 We have copied for you in the bundle that you have, 18 chair, a range of exhibits that show the sort of 19 material that children are given about the Barnardo's 20 services, if you like, and also Barnardo's own policies. 21 There is also material exhibited to Ms Good's 22 statement dealing with the number of allegations of 23 sexual abuse that Barnardo's had received and that's in 24 both BRD000238 and BRD000270. You may in particular 25 wish to look at, as I have indicated, exhibit 2, which</p> <p style="text-align: center;">Page 172</p>

<p>1 is the material given to the children about that service 2 and the statistics that are provided therein. 3 There is finally a very short statement dated 4 28 June at BRD000274, which brings up-to-date, I think, 5 the prevalent information and provides further detail 6 about the dates and hours of service of the advocacy 7 services that are provided and some information about 8 Barnardo's safeguarding referral processes, which you 9 may remember have changed rather since the Medway 10 Improvement Board's findings. 11 So, chair, I hope that brings us up-to-date with the 12 read material and that concludes the evidence for today. 13 THE CHAIR: Thank you very much, Ms Hill. 14 (4.00 pm) 15 (The hearing adjourned until 10.00 am on Tuesday, 16 17 July 2018) 17 18 19 20 21 22 23 24 25</p> <p style="text-align: center;">Page 173</p>	
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