

<p>1 Thursday, 25 October 2018</p> <p>2 (10.00 am)</p> <p>3 THE CHAIR: Good morning, everyone, and welcome to Day 14 of</p> <p>4 this public hearing. Mr Sadd?</p> <p>5 MR SADD: Good morning, chair and members of panel. Before</p> <p>6 we start, chair, we will today be hearing evidence from</p> <p>7 corporate witnesses from both councils and the police.</p> <p>8 We are very conscious that emotions may run high during</p> <p>9 the course of this evidence. However, chair, it is</p> <p>10 important that everyone seated in the public gallery in</p> <p>11 the hearing room allows the opportunity for the</p> <p>12 witnesses to be heard and avoids interruptions. This is</p> <p>13 not just out of respect for you and the inquiry's</p> <p>14 proceedings, but also so that everyone in the hearing</p> <p>15 room, including others seated in the public gallery, can</p> <p>16 hear the proceedings properly.</p> <p>17 THE CHAIR: Thank you, Mr Sadd. I endorse these comments.</p> <p>18 Could you now proceed?</p> <p>19 MR SADD: Chair, the first witness we are hearing from this</p> <p>20 morning is Professor Simon Hackett. He has provided</p> <p>21 a report to the inquiry. That's at INQ002045.</p> <p>22 PROFESSOR SIMON HACKETT (affirmed)</p> <p>23 Examination by MR SADD</p> <p>24 MR SADD: Good morning, Professor Hackett. You have</p> <p>25 provided a report to the inquiry. It is</p> <p style="text-align: center;">Page 1</p>	<p>1 dated August 2018 and it is entitled "Overview expert</p> <p>2 report on the development of the understanding of, and</p> <p>3 responses to, harmful sexual behaviours between children</p> <p>4 from 1945 to present day"; is that right?</p> <p>5 A. That's correct.</p> <p>6 Q. The panel have a copy of that report, and the whole of</p> <p>7 the report will be uploaded onto the inquiry's website</p> <p>8 over the next few days. I'm not going to go through it</p> <p>9 with you line by line. I intend taking you to</p> <p>10 particular topics and asking you to expand or elaborate</p> <p>11 on text that you set out there.</p> <p>12 Some documents that are aligned with your report may</p> <p>13 be used in the inquiry's report along with some publicly</p> <p>14 available documents, and those will be uploaded over the</p> <p>15 course of the next few days. Please can we go to your</p> <p>16 report, page 1, and your professional background. You</p> <p>17 are the Professor of Child Abuse and Neglect at</p> <p>18 Durham University and have, over the last 20 years,</p> <p>19 undertaken a considerable amount of research and written</p> <p>20 a number of papers and books on the topic of harmful</p> <p>21 sexual behaviour between children. Is that right?</p> <p>22 A. That's right.</p> <p>23 Q. Can we go straight, then, please, to the first part of</p> <p>24 your report, the introduction. This is where you look</p> <p>25 at the prevalence of child-on-child sexual abuse. At</p> <p style="text-align: center;">Page 2</p>
<p>1 paragraphs 1.1 to 1.3, you address this prevalence, and</p> <p>2 it is correct to summarise it that it is generally</p> <p>3 agreed that between a third to a quarter of all sexual</p> <p>4 abuse is carried out by those under 18.</p> <p>5 Is it difficult to establish an accurate figure</p> <p>6 because of the secrecy often involved in committing such</p> <p>7 acts and the variable ways of recording it?</p> <p>8 A. I think both because of the secrecy and variable ways of</p> <p>9 recording it, but also because this is a problem that</p> <p>10 has only relatively recently been acknowledged and</p> <p>11 understood. So I think all of those three things mean</p> <p>12 that indicators are not entirely reliable.</p> <p>13 Q. Page 5, please. Here you discuss the evolving</p> <p>14 terminology and the continuum, as it were, of child</p> <p>15 sexual behaviour. This is between paragraphs 2.1 and</p> <p>16 2.18. At 2.10, the bottom of page 6, you say that it's</p> <p>17 now recognised that sexual behaviours in childhood exist</p> <p>18 on a continuum from normal and developmentally</p> <p>19 appropriate, on the one hand, to highly abnormal and</p> <p>20 violent, on the other. Indeed, at page 10 of</p> <p>21 the report, you provide a model of the span of that</p> <p>22 behaviour.</p> <p>23 Could you explain in a little more detail, please?</p> <p>24 A. I think it's been really important, as awareness has</p> <p>25 grown about the problem of child sexual abuse by</p> <p style="text-align: center;">Page 3</p>	<p>1 children, to understand that this is not one categorical</p> <p>2 issue, that actually the behaviours involved range from</p> <p>3 low-level inappropriate behaviours to highly deviant and</p> <p>4 abusive behaviours. It's important to understand that</p> <p>5 any one child who presents with problems with sexual</p> <p>6 behaviour is likely to be expressing them in different</p> <p>7 degrees over a period of time. So I think the idea of</p> <p>8 a continuum has been proposed in order to try to guide</p> <p>9 professionals to make distinctions between children's</p> <p>10 sexual behaviours and the level at which they are</p> <p>11 displayed in order to be responding commensurately with</p> <p>12 the behaviours and the risks associated with those</p> <p>13 behaviours across this idea of a continuum.</p> <p>14 Q. We go over the page, please, to page 7, and at the</p> <p>15 bottom of the page, paragraph 2.13. There you address</p> <p>16 the distinction between abusive sexual behaviours and</p> <p>17 problematic sexual behaviours. Can you expand a little</p> <p>18 on that?</p> <p>19 A. I think the broad definition of sexually abusive</p> <p>20 behaviours by children is taken to indicate behaviours</p> <p>21 that involve a degree of coercion, disparity of power,</p> <p>22 manipulation and harm, whereas problematic behaviours</p> <p>23 may well be those that are developmentally more</p> <p>24 appropriate but are expressed inappropriately or in</p> <p>25 inappropriate contexts, where there may be no overt</p> <p style="text-align: center;">Page 4</p>

<p>1 elements of victimisation or coercion but, in a sense, 2 the behaviours are difficult and need guidance and 3 appropriate responses because they are out of step 4 either developmentally or poorly expressed in the wrong 5 kind of contexts, but it would be unfair to those 6 children expressing those kinds of behaviours to label 7 them as abusers or demonstrating abusive behaviour 8 because, in a sense, it's categorically and different 9 sets of behaviours to those that might be defined as 10 abusive.</p> <p>11 Q. From what you have understood of present-day training 12 and guidance, do you think that present-day residential 13 care staff of children in care homes are able to discern 14 that difference between the two?</p> <p>15 A. I think, broadly speaking, there has been some 16 developments in awareness on the range of sexual 17 behaviours by children. Certainly in the earlier days 18 of my own practice in the earlier 1990s on this topic, 19 it was assumed that almost all expressions of sexual 20 behaviour by children and young people were abusive and 21 harmful, whereas I think now there's much more of 22 a nuanced understanding of these behaviours, including 23 in relation to care staff.</p> <p>24 Q. In your view, should there still be intervention in 25 cases identified by staff of non-abusive, problematic</p> <p style="text-align: center;">Page 5</p>	<p>1 behaviour?</p> <p>2 A. I think, as with all children and young people who are 3 having -- expressing sexual behaviours, they rely on 4 their carers, parents, adults around them, to help guide 5 those behaviours in order for them to be expressed 6 safely in a way that doesn't cause problems for them or 7 other people. So even if something is problematic or 8 inappropriate, I think that needs professional guidance 9 or carer guidance for young people, in order to help 10 them to perhaps learn and develop in a healthy way 11 sexually. That is, of course, very different from 12 providing more intensive treatment for those children 13 who are expressing abusive behaviour. I think that's 14 a really important distinction that professionals, and 15 indeed parents, need to make.</p> <p>16 Q. Still with page 8, please, paragraph 2.15. You say: 17 "The term 'harmful sexual behaviour' ... is now the 18 preferred terminology ..."</p> <p>19 Is that the terminology that you think should be 20 widely adopted?</p> <p>21 A. I think so, yes, and we have moved away in the field 22 from talking about juvenile sexual offenders or 23 adolescents who sexually abuse to a broader 24 understanding of these behaviours on this idea of 25 a continuum. So harmful sexual behaviour for me is</p> <p style="text-align: center;">Page 6</p>
<p>1 an umbrella term that embraces behaviours that may be 2 harmful to others but also implicitly has -- damages the 3 child who's expressing those behaviours too. So it may 4 be harm towards self or others. I think this is a much 5 less stigmatising and pathologising term to use for 6 children who may be experiencing difficulties with 7 sexual behaviours.</p> <p>8 Q. I think it is also your view that the term 9 "peer-on-peer" is not appropriate to describe 10 adolescents abusing younger children. Is that right?</p> <p>11 A. I think peer-upon-peer abuse or peer-on-peer sexual 12 abuse has been proposed recently to describe the subset 13 of young people who abuse their peers, ie, children and 14 young people of the same age as them, roughly. Of 15 course, that's categorically a different issue to those 16 adolescents who target and abuse much younger, 17 pre-pubescent children. So I think we should avoid the 18 term "peer-on-peer abuse" if what we are talking about 19 is large age discrepancies between children.</p> <p>20 Q. Page 9, please, where you're developing at 2.17 the use 21 of the term "harmful sexual behaviour". You say at the 22 top of page 9 that the issue of children and young 23 people who sexually abuse other children no longer 24 features in the last two versions of Working Together. 25 We know there is a very recent version, as you identify</p> <p style="text-align: center;">Page 7</p>	<p>1 there, this year. Do you know why that is?</p> <p>2 A. I'm not entirely sure why that is. I think the guidance 3 has been perhaps broadened to look at principles -- core 4 principles about protecting children, and perhaps this 5 is an issue that is seen to be covered in that broader 6 guidance, without needing to be explicitly identified in 7 the -- certainly in the English and Welsh context. It 8 is interesting, however, that the National Guidance for 9 Child Protection in Scotland document does have 10 a section on children and young people who display 11 harmful or problematic sexual behaviour, so there are 12 some differences between the national -- the guidance 13 amongst the different nations within the UK.</p> <p>14 Q. Indeed, previously in the UK, in England and Wales, it 15 had been in the Working Together succession of 16 documents; is that right?</p> <p>17 A. Certainly from the 1991 version, which was the first 18 time that they had explicitly been mentioned within 19 Working Together, there was a section on children who 20 harm other children.</p> <p>21 Q. Part 3 of your report, please, page 11. Here you look 22 at the development of awareness and understanding of 23 harmful sexual behaviour from the 1980s to present. You 24 discuss that development and you say at 3.3: 25 "Given the lack of general awareness of child sexual</p> <p style="text-align: center;">Page 8</p>

<p>1 abuse itself, it's perhaps unsurprising that the 2 historical understanding of children as perpetrators was 3 so low." 4 Paragraph 3.8, please, if we can move on -- that's 5 page 13 -- you say that by the late 1980s there was 6 still little or no discussion about the management and 7 treatment needs of children and young people who were 8 perpetrating sexual offences, and you note from the 9 Masson Paper in 2000 that the problem had not been 10 characterised or officially recognised. 11 Would you have expected, Professor Hackett, at that 12 period, a local authority to have had policies or 13 procedures on the issue by that time? 14 A. No. 15 Q. Paragraph 3.11, please, page 14. Something you have 16 just touched on. You note that Working Together had 17 some 30 lines -- this is Working Together 1991, I should 18 say -- about how to deal with abuse carried out by 19 children and young people. You understand that this was 20 included in guidance because of a Social Services 21 inspector who was particularly interested in the issue, 22 that's included in the Working Together guidance. We 23 know that the county council in Nottinghamshire had 24 specific guidance in its own procedures in 1991. Is 25 that something that was generally the case amongst local</p> <p style="text-align: center;">Page 9</p>	<p>1 authorities, as far as you're aware? 2 A. To the best of my awareness, local authorities at that 3 time developed their policies and procedures in 4 conjunction with Working Together, so I would have 5 expected some reference within local procedures and 6 policies to the brief guidance within Working Together 7 at that time. That really set the framework for the 8 first time around responses to this issue. 9 Q. Page 15, please, paragraphs 3.13 and 3.14. You refer 10 there to a 1992 National Children's Homes report on 11 children and young people who sexually abuse other 12 children. You describe it as a landmark document. Why 13 do you see it as that? 14 A. Certainly in the UK context, this was the first time 15 that the issue had been looked at systemically and 16 seriously, and the NCH at the time drew together expert 17 opinion of people who, from a ground level, were very 18 concerned about the problem. So it has reflected 19 developing awareness of the existence of a group of 20 children and young people who were abusing other 21 children and this really set the context for the 22 professional landscape at the time. It really 23 identified for the first time the failings and the 24 problems inherent in the child welfare system in 25 response to this issue and set some targets for areas</p> <p style="text-align: center;">Page 10</p>
<p>1 that needed to be addressed. 2 Q. Page 16, please, paragraph 3.16. You note that the 3 period from the mid 1990s to the mid 2000s saw a steady 4 but not remarkable increase in awareness and knowledge 5 about the issue of harmful sexual behaviour. Again, as 6 we are moving on in time, what policies or procedures 7 would you have expected a local authority to have had 8 about harmful sexual behaviour, bearing in mind the 9 Working Together guidance of 1991 and the National 10 Children's Homes report that you have just mentioned? 11 So this is looking at the period from the 1990s to the 12 mid 2000s? 13 A. I think in the early or mid 1990s, guidance would 14 largely be underpinned by the Working Together document. 15 As research and awareness began to grow, as training 16 courses began to be put on for local authority workers 17 on this issue, throughout the late 1990s and early 18 2000s, I think we saw a bit more of a sophisticated 19 approach to the area of work, and in my review in 2005 20 of the state of policy and practice with my colleague 21 Helen Masson, we reviewed the state of policy and 22 procedures across local authorities in the UK. We found 23 that a majority of local areas that the time had 24 guidance. 25 There was also a period of time when the</p> <p style="text-align: center;">Page 11</p>	<p>1 AIM Project, which is an initiative based in 2 Greater Manchester, began to develop interagency 3 procedures to deal with this issue from the early 2000s. 4 Q. AIM standing for what? Can you just remind us? 5 A. It stands for "Assessment, Intervention and Moving on". 6 It was an interagency project that tried to develop 7 procedures initially in Greater Manchester. These AIM 8 procedures were then adopted by many local authorities 9 from the beginning of the new millennium as a way of 10 articulating the interagency response and bringing 11 together Youth Justice and Child Welfare Services for 12 joint assessments and responses to the issue. 13 Q. In the 2005 paper that you have just mentioned, yes, you 14 say there was a more sophisticated approach, as you have 15 just told the inquiry, but you say that the response 16 from therapeutic services about the state of out-of-home 17 care for children with harmful sexual behaviour painted 18 "a woeful picture" of both the availability and quality 19 of care placements and that there was insufficient 20 specialist residential resource. In what circumstances 21 would a child, at that period, displaying harmful sexual 22 behaviour be provided with a specialist placement? What 23 would be the threshold, in effect? 24 A. I think the thresholds varied substantially across the 25 country, actually. Our research in the mid 2000s</p> <p style="text-align: center;">Page 12</p>

<p>1 painted a picture of tremendous variability in terms of 2 the way that cases were handled and also the 3 availability of local assessment and residential 4 facilities. So in some cases, at that point in time, 5 the decision to provide a specialist placement for 6 children was a reflection of the lack of availability of 7 local resource. So many children were placed in 8 out-of-borough specialist placements, simply because -- 9 not necessarily because the threshold for their 10 behaviour was such that a decision had been made that 11 they had to be specifically accommodated in a specialist 12 residential provider, but because there was no suitable 13 placement within a local area.</p> <p>14 Q. Should the inquiry understand that "specialist" means 15 being entirely separated from other young people, or 16 simply more stringent supervision?</p> <p>17 A. So specialist residential placements tend to be -- my 18 interpretation of that term is that they are providers 19 that only offer accommodation for children and young 20 people who have displayed harmful sexual behaviour. 21 These tend to be in small group homes.</p> <p>22 Q. Do you know what the current level of provision 23 nationally is?</p> <p>24 A. I think more recently we have seen a growth in those 25 kinds of specialist provision. The more recent evidence</p> <p style="text-align: center;">Page 13</p>	<p>1 from a review that was done by Smith and colleagues only 2 a matter of a few years ago that updated our research 3 from the mid 2000s continued to raise the availability 4 and quality of specialist placements as a problem. So 5 I think the position is still rather patchy, even though 6 we have seen a growth of that provision in the 7 intervening ten years.</p> <p>8 Q. From your own research, do you have any assessment of 9 the quality of provision?</p> <p>10 A. Certainly in our 2005 report, when we consulted I think 11 around about 200 respondents who were involved in this 12 work across the UK, a very small minority were satisfied 13 with the quality of that provision, so it was a question 14 of a lack of availability but also, where provision was 15 available, some concerns about its quality.</p> <p>16 Q. And 13 years on, is the picture a better one, do you 17 know?</p> <p>18 A. My sense of that from working with care providers is 19 that there is some very good quality provision around in 20 the UK, but that's not necessarily reflected everywhere.</p> <p>21 Q. Paragraph 3.22, page 18, please. You reflect on some of 22 the ongoing problems identified by the NSPCC regarding 23 the interagency response to harmful sexual behaviour, 24 including ongoing lack of appropriate training and 25 support for staff. What do you think can be done to</p> <p style="text-align: center;">Page 14</p>
<p>1 address these ongoing problems?</p> <p>2 A. The framework that the NSPCC has published I think is 3 a really important step forward, and this is an 4 opportunity for local agencies to audit their practice 5 in relation to children and young people with harmful 6 sexual behaviours, to bring multi-agencies together in 7 order to look at the strengths and relative weaknesses 8 in addressing these issues, and also has promoted 9 a sense of standardisation of practice in terms of 10 assessment, availability of intervention services, and, 11 importantly, training. Training I think to date has 12 relied on rather short courses -- one-day courses 13 provided by local Safeguarding Children's Boards -- as 14 part of a suite of interagency training. I think we 15 probably need to have a better system of more intensive 16 training for those staff who are working with this issue 17 more regularly.</p> <p>18 Q. As you have just mentioned, still on page 18, 19 paragraph 3.23, please, you have mentioned the NSPCC 20 framework, and you say it's been adopted by several 21 local authorities. Over the page, please, to page 19, 22 paragraph 3.25. You note that at present the majority 23 of local Safeguarding Boards acknowledge the issue of 24 harmful sexual behaviour in procedures and documents but 25 "despite previous attempts to encourage government to</p> <p style="text-align: center;">Page 15</p>	<p>1 develop a comprehensive policy on this issue, there is 2 still no national strategy or overarching service 3 delivery model in relation to this issue across the UK, 4 though the NSPCC operational framework is a significant 5 step forward towards in this regard."</p> <p>6 To what extent, if any, do you think that the 7 absence of a framework or delivery model impacts on 8 safeguarding of children in residential or foster care?</p> <p>9 A. I think obviously local authorities need, and care 10 providers need, to take their reference point from 11 somewhere. I and a number of other people working in 12 this field have encouraged government, over a number of 13 years, to try to come up with a -- demonstrate 14 leadership by describing an operational framework that 15 really would bring together/co-ordinate agencies to be 16 clear in terms of responses at different levels of 17 intensity across the UK, to really try to move beyond 18 this rather patchwork postcode lottery that still exists 19 in relation to availability of services. So I think 20 that, in the absence of that, it often comes down in 21 local areas to what services are available, whether 22 there are trained and interested workers who have really 23 taken this work on and have led to, from a ground-level 24 approach, the coordination of services. 25 I think obviously that has resulted in some very</p> <p style="text-align: center;">Page 16</p>

<p>1 excellent practice in areas of the UK, but because it 2 hasn't been led from government, there is variability in 3 whether that's occurred across all areas in the UK. 4 Q. Section 4 of your report which is at page 20 we are 5 going to come back to, but that section deals with the 6 evolution of the criminal justice and child welfare 7 response to the issue of sexual offences by children. 8 I want to go, though, to section 5, which starts at 9 page 33 of your report. If we can go, please, to 10 paragraph 5.8 at page 35 -- do you have that? 11 A. Yes. 12 Q. You say, starting at the top of that paragraph: 13 "It is now recognised that pre-adolescent children 14 with sexual behaviour problems are a diverse group with 15 differing levels of need ... cases involving younger 16 children should be dealt with in qualitatively different 17 ways to those involving adolescents." 18 By "cases involving younger children", is this in 19 relation to the age of the alleged perpetrator? 20 A. Yes. 21 Q. Do you think procedures are set up in such a way to 22 allow for different responses in this way or are cases 23 handled generically, regardless of age? 24 A. I think there has been a tendency to lump all children 25 and young people who have demonstrated harmful sexual</p> <p style="text-align: center;">Page 17</p>	<p>1 behaviours together as if they are all -- all their 2 behaviours are all similar with the same likely outcomes 3 and the same motivating factors. The issue about 4 pre-adolescent children I think is really important 5 currently within the field because, previously, when 6 people started to make attempts to address the issue of 7 adolescent perpetrators of sexual abuse, we took the 8 reference point from research primarily derived from 9 adult sex offenders and it took us a long time to 10 unlearn some of that, those approaches; in other words, 11 to respond to young people as adolescents rather than as 12 mini adults. I think we run the risk at the moment of 13 doing the same thing for much younger children, 14 pre-adolescents, whose motivating factors underpinning 15 their abusive sexual behaviours are likely to be 16 different from teenagers or adolescents. So I think 17 there's a lesson from history there in terms of how we 18 move forward in relation to the needs of much younger 19 children. 20 To be specific, much younger children are highly 21 likely themselves to be victims of sexual abuse and 22 their behaviours, their abusive and problematic sexual 23 behaviours, are much more likely to be a direct 24 consequence of sexualisation through abuse. So the 25 intervention response for those children should be much</p> <p style="text-align: center;">Page 18</p>
<p>1 more akin to that of children who have experienced 2 victimisation rather than models of practice that have 3 been derived on adult or adolescent sexual offenders, 4 for want of a better term. 5 Q. Indeed, Professor Hackett, this is something you come on 6 to discuss at paragraph 5.14. This is page 36. You 7 say: 8 "It is now recognised that there is no one simple 9 cause for harmful sexual behaviour in childhood." 10 You discuss what you describe as the most promising 11 theoretical model of causes, and that's at page 37, 12 please, paragraph 5.15. You say that that's described 13 in a paper by Ward and Siegert, and they put forward 14 five pathways which you set out at pages 37 to 38. The 15 second pathway, which we can see at the bottom of 16 page 37, is labelled "Distorted sexual scripts", and 17 suggests that one pathway is that a young person can 18 have distorted beliefs and thought processes, sometimes, 19 as you have just mentioned, reflective of those who have 20 been abused as younger children. Indeed, you say that 21 should be understood as suggesting that one of 22 the causes of those children then committing harmful 23 sexual behaviour is that they will have been sexually 24 abused themselves, as you have pointed out. 25 The inquiry has heard evidence, for example, from</p> <p style="text-align: center;">Page 19</p>	<p>1 a former resident of a children's home, known by L46, 2 that she was sexually assaulted in the context of 3 bullying. How should the inquiry understand this type 4 of behaviour to fit into the pathways? 5 A. Sorry, for me to be clear, how should the inquiry 6 understand bullying sexual behaviour? 7 Q. Yes. 8 A. I think that probably links more closely with this 9 particular pathway about anti- social thinking that Ward 10 and Siegert have proposed. This is often used to 11 explain why children and young people whose experiences 12 and backgrounds are more characterised by general 13 criminality, rule breaking and boundary violation across 14 different areas of their lives are sexualised during 15 adolescence, and I guess sexual bullying is a good 16 example of this, if you like, broader portfolio of 17 deviance and rule breaking and boundary violation that 18 exists within a peer group context. 19 Q. 5.22, please, page 39. You develop this through to 20 5.25. You note that it was previously assumed that the 21 majority of adolescents who sexually abused others were 22 at high risk of continuing to sexually offend into 23 adulthood. But based on more recent studies, as you set 24 out, that's no longer the understanding now. Is that 25 right?</p> <p style="text-align: center;">Page 20</p>

<p>1 A. It's absolutely the understanding. This is a really 2 important point for the inquiry to understand, that most 3 children and young people who present with harmful 4 sexual behaviours grow out of it by their mid 20s, so 5 the evidence is very strong in support of this idea of 6 adolescent-limited sexually abusive behaviour. 7 Q. Then we go, please, to section 6 of your report. This 8 is where you look in more detail at the abuse histories 9 of children -- this is page 43, I should have said, 10 Professor Hackett. You look at the abuse histories of 11 children who sexually abuse other children. You say, at 12 paragraph 6.7, page 44 -- do you have that? 13 A. Yes. 14 Q. This is at the top of the page. You note that the 15 overwhelming majority of victims of all forms of abuse 16 do not go on to abuse others. Using the idea of a cycle 17 of abuse to explain or predict abusive behaviour in 18 young people you say is damaging to victims. Why 19 damaging to victims? 20 A. I think for children who have lived with sexual abuse, 21 assuming they are therefore at risk of abusing others, 22 does a great disservice to the majority of victims who 23 are struggling with that experience and to make their 24 lives -- to turn their lives around as a consequence of 25 that abuse experience. This is probably -- the</p> <p style="text-align: center;">Page 21</p>	<p>1 misunderstanding about this point is probably related 2 research that was originally done in relation to adult 3 sex offenders in the 1970s and '80s, particularly in 4 North America, where it was found that most adults who 5 sexually offend began -- had themselves started to abuse 6 when they were adolescents. 7 So it was therefore misassumed that those who were 8 presenting with these behaviours in adolescence would 9 carry on into adulthood. I think what I have tried to 10 do in the report is to make a distinction between the 11 fact that a history of sexual abuse in childhood might, 12 for those children who do go on to sexually offend or 13 abuse other children, might be explanatory. In other 14 words, it might be the underpinning developmental 15 experience that sets the context for that person's 16 subsequent behaviour. But that's very different from 17 then pathologising most victims of abuse as potential 18 abusers. That logic doesn't follow. 19 Q. Indeed, that's the thrust of what you say at 20 paragraph 6.9 on the same page. At 6.10, looking at it 21 the other way around, as to whether those who have 22 exhibited harmful sexual behaviour had previously been 23 the victims of child sexual abuse. At paragraphs 6.10 24 to 6.12, you refer to research showing that somewhere 25 between I think it is 25 per cent and 84 per cent of</p> <p style="text-align: center;">Page 22</p>
<p>1 those who exhibit harmful sexual behaviour had 2 previously been the victims of child sexual abuse. Is 3 there any reason for such a wide variation? 4 A. I think there are a range of reasons. Looking at those 5 studies, they have used different definitions of what 6 constitutes sexual abuse. They have also used different 7 sources of data. Many of them have relied on case file 8 analysis, which may not be an accurate record or it may 9 well be, retrospectively, that people haven't asked 10 children presenting with these behaviours about their 11 own abuse experiences rather than talking with them 12 directly. I think operational, definitional issues, 13 data, methodical issues, have all accounted for this 14 wide variety. As you will note from the table that 15 I provide on page 45, some of the studies involve rather 16 small numbers as well. 17 Q. Should there be any confidence factor percentage figure 18 that we could rely on as a reflection of -- 19 A. Well, of course, my own study in 2013 is by far the 20 best, and it's the largest UK study of children and 21 young people presenting with these behaviours. And when 22 we looked at this, we saw about half of the young people 23 in that sample of 700 had experiences -- either 24 confirmed or very strongly suspected experiences -- of 25 sexual abuse in their background. As you will note,</p> <p style="text-align: center;">Page 23</p>	<p>1 a significant proportion also had experienced physical 2 abuse, et cetera. 3 I mean, the overwhelming message, I think, looking 4 at -- despite the range of studies that exist, the 5 overwhelming message is that the abuse histories and 6 trauma histories of children who present with harmful 7 sexual behaviours are much more elevated than you would 8 expect in the general population. In other words, 9 trauma is a key indicator and a key causal factor for 10 many children about their subsequent expression of 11 harmful sexual behaviour. 12 Q. Page 48, please, paragraph 6.21. You say that 13 two-thirds of 700 cases analysed had experienced at 14 least one form of abuse in the past and at least half of 15 the total sample had experienced a form of abuse other 16 than sexual. So, at 6.22, should the inquiry then 17 conclude that children exhibiting harmful sexual 18 behaviour are likely to have histories of general 19 maltreatment or trauma, as you describe, but not 20 necessarily sexual abuse? 21 A. I think there's a group of children whose own trauma 22 histories may not have necessarily included sexual 23 abuse, or at least that might not be the only form of 24 abuse that they have experienced, where other forms of 25 trauma have then caused them difficulties in relation to</p> <p style="text-align: center;">Page 24</p>

<p>1 interactions with other people, intimacy, and often 2 those problems become sexual in nature during puberty. 3 Q. Page 49. Between paragraphs 6.23 and 6.25, you use the 4 phrase "polyvictimisation". Should that be understood 5 to be the issue that we have just been talking about? 6 What does it mean? 7 A. Sorry about the jargon. This is a dreadful American 8 term but from colleagues, respected colleagues, in the 9 US who have used the term "polyvictimisation" to 10 describe multiple forms of abuse in children's 11 backgrounds, and it's been proposed that this is 12 a really important term to understand, really, if you 13 like, the tipping point for many children from being 14 victims towards harming other people, that this presence 15 of polyvictimisation, in other words, sexual abuse in 16 the context of physical abuse, domestic abuse, neglect 17 in their backgrounds, often poor levels of parenting, 18 poor models, role models, in their lives. All of these 19 factors interact to make it more likely for children to 20 experience problems with their own sexual behaviour 21 regulation, in adolescence particularly. 22 Q. We are going to move on, Professor Hackett, to 23 section 7, but on the way there, if we go to page 51, 24 you can see that what you have provided there is a model 25 for explaining possible associations between</p> <p style="text-align: center;">Page 25</p>	<p>1 victimisation and harmful sexual behaviour. In effect, 2 it sets out in a diagrammatic form what you have been 3 explaining. 4 Section 7, please, page 52. Here you deal with the 5 recognition of sexual abuse between children in care and 6 what has been understood about this form of abuse since 7 1945 to the present day. You begin by saying that in 8 the general literature this has not been a focus of 9 research and therefore discussion of children in care 10 has been restricted to looking at those with harmful 11 sexual behaviour who are then placed in care settings as 12 a consequence of their behaviour. This is looking by 13 contrast -- it is not looking at those who offend for 14 the first time whilst in care or who are victims whilst 15 in care. I say the word "offend"; I mean who exhibit 16 harmful sexual behaviour for the first time in care. So 17 there is a contrast to be had there; is that right? 18 A. I think so, yes. 19 Q. Paragraph 7.5, page 53. You refer to your own study in 20 2013, which you have already touched on, which suggests 21 that a third of people referred to UK services over 22 a nine-year period then entered into the care system. 23 At 7.9, over the page, 54, you say that, for some 24 children whose sexually harmful behaviour is influenced 25 by their home environment, coming into care can actually</p> <p style="text-align: center;">Page 26</p>
<p>1 prevent further harmful sexual behaviour. Have 2 I understood that correctly? 3 A. Yes. I think one of the key distinctions about children 4 with harmful sexual behaviours is that often their 5 behaviours are very contextually driven and influenced 6 by the environment in which they are living, and 7 certainly I have seen very many examples of children who 8 have been moved out of highly abusive and sexualised 9 environments and put in good-quality care contexts that 10 have effectively helped them to not express further 11 harmful sexual behaviours. In other words, the 12 context -- providing a safe, supportive and nonsexual 13 care context in itself is enough to stop the further 14 display of harmful sexual behaviour. 15 In addition to that, however, I think that's 16 a really important point for many care providers, 17 because there are examples of children and young people 18 for whom that is not recognised in relation to 19 attribution of high levels of risk for young people who 20 are continued to be regarded as high risks for future 21 sexually abusive behaviour when the evidence is not 22 there. 23 Q. You describe what you call an overly risk-averse 24 approach to children who come into care having exhibited 25 harmful sexual behaviour before?</p> <p style="text-align: center;">Page 27</p>	<p>1 A. Yes. So if the prevailing thought is that most of these 2 children and young people continue to sexually offend 3 and will continue to sexually offend through adolescence 4 into adulthood, then that obviously leads to 5 a philosophy of care that is very restrictive in terms 6 of the life opportunities of those people. If, however, 7 the key evidence from outcome studies is that the 8 majority of these children and young people will in 9 effect grow out of the behaviours in late adolescence 10 and early adulthood, then the care task becomes 11 different, it becomes one of helping nurture young 12 people's life opportunities in order to make sure that 13 the restrictions placed on them don't inhibit their 14 future chances, in terms of, say, for example, 15 educational achievement, unnecessarily. So there is 16 a balance to be had, I think, between risk management 17 and protecting other people around that child, but also 18 not squashing that child's development so significantly 19 that it actually prevents them from moving on in their 20 lives. 21 Q. My simplistic understanding is a balance between being 22 defensive, on the one hand, and being positive, on the 23 other, in trying to address those needs? 24 A. Being safe, on the one hand, and also opening up 25 opportunities for appropriate development, on the other.</p> <p style="text-align: center;">Page 28</p>

<p>1 Q. Paragraph 7.11, please, page 55. You say that the 2 assumption that young people in care are particularly 3 prone to exhibiting harmful sexual behaviour is highly 4 problematic, pointing out there that children in care 5 are often subject to significantly more scrutiny and 6 behaviour is more likely to be reported. It may be that 7 you have already answered this question: do you think 8 that the care setting cultivates an overly cautious 9 approach to intervention in harmful sexual behaviour? 10 I suspect the answer is yes, isn't it?</p> <p>11 A. I think that children in the care system are often 12 subject to scrutiny about their conduct, including their 13 sexual conduct, in a way that children perhaps living in 14 family contexts are not subject to professional 15 scrutiny. So in some cases, I think children in the 16 care system, when they're exhibiting normal sexual 17 behaviours, are deemed to be displaying inappropriate or 18 problematic behaviours, not because of the nature of 19 the behaviours themselves, but the context in which 20 they're expressing those behaviours. So sometimes the 21 problem is the context, not the behaviours itself, and 22 that's, I think, a really important distinction to make.</p> <p>23 Q. From your experience and research, do you think it's 24 difficult for residential care staff and foster carers 25 to work out whether a child's sexual behaviour is normal</p> <p style="text-align: center;">Page 29</p>	<p>1 experimentation, on the one hand, or abusive, on the 2 other?</p> <p>3 A. I think it is a problem for care staff, but also more 4 broadly within society, that adults struggle to 5 understand what is normal and abnormal in relation to 6 expressions of children/adolescent sexual behaviour 7 across the board, and particularly with the changing 8 nature of sexual interactions between children, the use 9 of online sexual interactions, et cetera, these are all 10 things that mean that there's long since been problems 11 for adults in trying to work out and support children at 12 different levels, and that I think includes care staff. 13 They're often placed in very difficult situations of 14 having to manage sexual interactions between children in 15 a care setting without a great deal of guidance and 16 training on those issues.</p> <p>17 Q. 7.12 to 7.14. You say that within the care context, 18 there is a general lack of understanding about 19 adolescent sexual development and normative sexual 20 behaviour, and that can result in children in care being 21 regarded as "sexually deviant" for behaviour that would 22 otherwise be regarded as normal, as we have just 23 described. Is the solution more training?</p> <p>24 A. I think so, yes; more training on the evidence around 25 what constitutes normal and inappropriate and harmful</p> <p style="text-align: center;">Page 30</p>
<p>1 sexual behaviours. We now have some tools to try and 2 help and support workers with this task, so these are 3 relatively recently adopted. So the idea of a continuum 4 of sexual behaviours that I have proposed is one of 5 those tools, but there is another tool called the Brook 6 Traffic Light Tool that tries to help professionals and 7 other people distinguish between levels of behaviour. 8 These are important steps forward, I think, that help to 9 provide at least some guidance for professionals.</p> <p>10 Q. Page 58, please, paragraph 7.25 at the bottom of 11 the page. There you say that existing evidence suggests 12 about half of sexual abuse cases in residential care 13 refer to abuse between children. But you go on to say: 14 "This figure may be an underrepresentation of 15 the true scale of the problem, given the high likelihood 16 that peer sexual abuse in care has been downplayed by 17 professionals who have seen it as an exploratory 18 adolescent sexual behaviour." 19 Do you have any sense of what the true scale is?</p> <p>20 A. I think I'd be guessing about the true scale. 21 Obviously, if a quarter to a third of all sexual abuse 22 reported across contexts relates to children and young 23 people, and at least half of all abuse within care 24 relates to young people, then obviously that's an 25 elevated level. But in terms of accurate prevalence or</p> <p style="text-align: center;">Page 31</p>	<p>1 incidence figures, I think it would be very difficult -- 2 unwise of me to speculate.</p> <p>3 Q. Page 59, please, paragraph 7.26. There you note that 4 few studies have examined sexual abuse between children 5 in foster care. Do you know why that is?</p> <p>6 A. There have not been that many studies, and not many 7 recent studies, about the prevalence of sexual abuse 8 within residential care let alone foster care. So 9 I think it is part of this under-researched area.</p> <p>10 Q. 7.29 on the same page. There you discuss research into 11 the nature of sexual behaviour between peers in care, 12 highlighting that institutional culture is one of 13 the main factors influencing the expression of sexual 14 and harmful sexual behaviour in care settings. You note 15 a recent description of this as "the rotten basket 16 approach rather than the rotten apple approach". 17 What does the research suggest that risks are for 18 children in care, in terms of their sexual development 19 and potentially developing harmful sexual behaviour?</p> <p>20 A. I think this is an important distinction, this rotten 21 apple and rotten basket approach, in terms of trying to 22 move away understandings from just blaming individual 23 children for being bad in relation to their sexual 24 behaviour to more understanding the context in which 25 that behaviour is expressed, and certainly in care</p> <p style="text-align: center;">Page 32</p>

<p>1 settings we know that children in care settings are much 2 more vulnerable to child sexual exploitation, being made 3 vulnerable to other adults and children around them, and 4 makes it harder for them to achieve levels of 5 achievement in educational contexts, et cetera. 6 Also, if you're a young person in the care system, 7 the opportunities for you to develop normal intimate 8 peer sexual relationships are obviously constrained 9 within the setting in which you're residing. So I think 10 there are a number of risks that are inherently part of 11 being moved out of home care into out-of-home care that 12 make it more difficult for children to navigate the 13 challenges associated with sexual development through 14 adolescence. 15 Q. Page 60, please. There at paragraph 7.30 you refer to 16 a 2002 study which highlighted how macho care cultures 17 affected not only members of staff related to girls and 18 boys in care -- sorry, how they related to boys and 19 girls in care, but also how young people related to one 20 another. You say: 21 "Sexist and homophobic 'jokes' among colleagues 22 created an environment in which it was difficult to 23 detect, name and tackle abuse." 24 Does that mean that in such cultures, from your 25 research, harmful sexual behaviour is more likely to</p> <p style="text-align: center;">Page 33</p>	<p>1 occur and less likely to be detected or tackled 2 properly? 3 A. I think these cultural aspects provide in some ways the 4 foundations upon which harmful sexual behaviour can 5 breed within peer group contexts. 6 Q. Paragraph 7.34, please, page 61. There you note a study 7 from Christine Barter in 1997 which concluded that 8 childcare social workers and residential social workers 9 usually denied or ignored peer sexual abuse in care or 10 don't know how to deal with it. At page 62, paragraph 11 7.37 to 7.38, you refer to studies regarding the 12 placement of children who are victims and perpetrators 13 of sexual abuse together, and that the recommendations 14 of the 1997 Utting Report were not followed. Has this 15 position now changed? 16 A. This was 2014 research that claimed there's still 17 problems from the 1990s in relation to victims and 18 perpetrators being placed together. I think placement 19 providers are now much more sensitised to the dynamics 20 of the peer group in which they are working and 21 accommodating. I think now there is much more awareness 22 of the need to look very carefully at risks presented by 23 young people on placement. 24 But of course, the issue for many agencies and local 25 authorities is about where to place young people and the</p> <p style="text-align: center;">Page 34</p>
<p>1 availability and quality of placements, which sometimes 2 mean, you know, they're really stuck in terms of how 3 best to provide a good living context for young people, 4 as we talked about earlier. 5 Q. From listening to you, it seems that the change in 6 understanding a placement is a very recent one? 7 A. Certainly over the last ten years, I've noticed that 8 placement providers are much more sensitised towards 9 those issues than they had been previously. 10 Q. Page 63, please, paragraph 7.40. You refer to four 11 elements of policy suggested by Farmer and Pollock in 12 2003 as to what could help prevent sexual abuse in care. 13 Do you endorse those suggestions 15 years on? 14 A. Absolutely. I think those are really clear sets of 15 recommendations. They are also borne out by a recent 16 doctoral study that a colleague, Gemma McKibbin, has 17 undertaken that has asked children and young people with 18 harmful sexual behaviours for their own recommendations 19 about how their behaviours could have been stopped. One 20 of the things that -- well, two of the things that they 21 said within this study echo Farmer and Pollock's 22 findings 15 years ago. One is they need better sex 23 education and help with managing their use of 24 pornography, and the second was they needed their care 25 placements to be safe for them in order to help them</p> <p style="text-align: center;">Page 35</p>	<p>1 develop appropriately without expression of harmful 2 sexual behaviour. So I would absolutely endorse those 3 four points and I think they are also backed up by more 4 recent evidence. 5 Q. Page 65, please, paragraph 7.45 at the top of the page. 6 There you note that consensual sexual relationships 7 within care homes are likely in practice to result in 8 one young person moving placements to enable the 9 relationship to continue safely outside the confines of 10 the home. You say the understanding of the consent is 11 clearly a key concept. What additional measures could 12 help to inform caregivers' understanding of consent? 13 A. I know this is an additional measure, but actually 14 talking to children and young people about these issues 15 and understanding the realities of their own attempts to 16 seek consent and how they form relationships, 17 particularly in the somewhat restricted environment of 18 a care context, would be important, I think. 19 Q. At page 66, picking up on the earlier continuum model, 20 you set out a model of care settings and harmful sexual 21 behaviour ranging from healthy, to inappropriate, to 22 problematic, to abusive to violent. We see that running 23 across the page. Under the heading "Abusive" the third 24 bullet point notes -- so looking at the fourth along: 25 "Policies and procedures which govern the care</p> <p style="text-align: center;">Page 36</p>

<p>1 context insufficiently guide the response required to 2 address the issues." 3 What more could or should be done about that? 4 A. I think, in a sense, some of what I've put within this 5 rather speculative model, I should say, that I developed 6 for the inquiry of healthy care contexts might actually 7 be the response to that particular point. So care is 8 taking an active and consistent approach to being 9 guardians, feeling equipped and empowered to support 10 children in the care context, particularly around sexual 11 behaviour and sexual development, strong structures, 12 clear roles and responsibilities that support healthy 13 interpersonal relationships in care systems. Those 14 kinds of things I think would be my ideal care context 15 that would perhaps address some of these issues. 16 Q. Can we go back, then, please, to part 4 of your report. 17 It starts at page 20, but I want us to look at 4.28, 18 which is at page 28. This is the section where you are 19 looking at the evolution of the criminal justice and 20 child welfare response to issues of sexual offence 21 against children. At paragraph 4.28 you refer to a 2013 22 joint inspection report which found little evidence of 23 proactive monitoring of the effectiveness of 24 multi-agency work on harmful sexual behaviour. Do you 25 think there was a failure across all agencies or</p> <p style="text-align: center;">Page 37</p>	<p>1 a particular agency? 2 A. The key aspect of this inspection report was that it was 3 a joint inspection report. I think one of the things 4 that they found was that there were problems in the 5 multi-agency response, so information sharing and 6 practice across agencies, so I think this finding 7 relates to multi-agencies rather than one single agency. 8 Q. Professor Hackett, is current practice that children 9 alleged to have sexually offended are all treated as 10 victims as well as alleged perpetrators? Is that your 11 understanding of current practice? 12 A. They're not all treated as victims, but I think all 13 responsible intervention providers should be alert to 14 the possibility of abuse or trauma in that child's 15 background, and that any intervention response now is 16 not just focused on offence-specific work but more 17 holistic -- or should be more holistic, that actually 18 looks at that child's individual circumstances, 19 including their family and early life experiences, as 20 well as their current functioning and their future 21 goals. In other words, we have moved beyond a situation 22 where the sponsor should just be focused on harmful 23 sexual behaviour, particularly if we think that's 24 a symptom of other aspects of their development and life 25 experience. We should be not just treating the symptom,</p> <p style="text-align: center;">Page 38</p>
<p>1 but we should be actually looking at the causes, and 2 I think that's now the prevailing approach. 3 Q. What steps do you think should be taken to avoid the 4 risk of those who are exposed to the criminal justice 5 system as a consequence of harmful sexual behaviour 6 being actually harmed by that process? 7 A. I think there's a broader discussion to have about the 8 appropriateness of legislative and policy frameworks 9 derived on for adult sex offenders, such as things like 10 sex offender registration, because we know that 11 labelling children who are developmentally not fully 12 formed as sex offenders and the life consequences of 13 being labelled as sex offenders through some of these 14 legislative policies and frameworks means that actually 15 we are making it less likely that they can live 16 offence-free lives, particularly when we consider the 17 evidence that we have talked about, in terms of the low 18 rate of recidivism for these children and young people. 19 I think we really need to rethink our philosophical and 20 policy-related approach to this group of children and 21 young people. So it is right we take seriously their 22 harmful sexual behaviour, we protect and we offer 23 support to victims, but also we need to be mindful that 24 these are, first and foremost, children, not just 25 offenders.</p> <p style="text-align: center;">Page 39</p>	<p>1 Q. Do you think that Child Protection and Youth Justice 2 responses to harmful sexual behaviour are well aligned? 3 A. They can be well aligned. I think elsewhere in the 4 report I have talked about how the joint procedures that 5 are often embedded through the AIM philosophy helpfully 6 brings together Youth Justice and Child Welfare agencies 7 in joint assessments and decision making, but I think 8 the multi-agency inspection that we have just talked 9 about, some of the evidence from the review by Smith and 10 colleagues about recent practice paints a rather mixed 11 picture on whether this is consistent across the UK. 12 Hence the need for a topdown, overarching strategy that 13 actually brings together some of these principles in an 14 overarching national framework, I think. 15 Q. Page 77 of your report, please, section 9. Section 9 16 deals with the key elements of how professionals should 17 address concerns or allegations of sexual abuse of 18 children in care by other children. To summarise, your 19 view, Professor Hackett, is that all staff in the care 20 system, including residential and foster carers, should 21 be trained and, at the very minimum, should base their 22 responses on the principles and approaches set out in 23 local procedures. You say that carers should not be 24 involved in investigating or questioning the children, 25 but should pass information on and then be involved in</p> <p style="text-align: center;">Page 40</p>

<p>1 multi-agency meetings and assessment of risk. You note 2 at page 80, paragraph 9.13, please, that in your 2014 3 research, you were told frequently by foster carers that 4 they were not given important information about 5 allegations faced by children in their care or the risks 6 associated with their behaviour. In your view, does 7 that impede the foster carers' ability to identify or 8 respond to harmful sexual behaviour?</p> <p>9 A. Absolutely. How can they deal with and manage 10 appropriately risks if they are not informed about the 11 nature of those risks? I have to say that one of 12 the things that foster carers told us was that they felt 13 that they had not been given this information by 14 professionals in some instances because the 15 professionals assumed that they wouldn't agree to care 16 for or look after young people if they were to find out 17 the true picture. But of course this is really unsafe 18 child protection practice.</p> <p>19 Q. From your understanding, are you aware of whether foster 20 carers are in general given greater information now?</p> <p>21 A. This was a relatively recent publication echoing nine 22 years' worth of practice. I think it would now be very 23 poor – established very poor practice not to give 24 foster carers this kind of information, but I can't say 25 with any absolute confidence that this is always the</p> <p style="text-align: center;">Page 41</p>	<p>1 case in current practice.</p> <p>2 Q. Page 81, paragraph 9.17. You think that children, both 3 victims and perpetrators, need someone who can help them 4 navigate and understand the system, because many say 5 they don't understand.</p> <p>6 We go to section 10, please, starting at page 83. 7 You address how professionals have addressed concerns 8 and allegations in relation to children in care in 9 practice. You say that before the late 1980s, good 10 carers and professionals may not have understood the 11 issue of sexual abuse between children, but should still 12 have been concerned about general welfare, sexual 13 well-being and the sexual behaviour of children and 14 young people in care. At paragraph 10.7, please, 15 page 84, you say while the focus has been on failure to 16 respond to harmful sexual behaviour appropriately, there 17 are likely many instances of good practice in spite of 18 lack of guidance.</p> <p>19 Professor Hackett, do you think the problem would 20 have been one of inconsistent practice in that case?</p> <p>21 A. Absolutely, yes, yes.</p> <p>22 Q. Finally, at section 8 of your report, this starts at 23 page 67, section 8 deals with the impact of harmful 24 sexual behaviours on victims and challenges that 25 children face in disclosing sexual abuse by another</p> <p style="text-align: center;">Page 42</p>
<p>1 child. Paragraphs 8.17 to 8.18, you set out some of 2 the significant impediments to disclosure, starting at 3 page 71, please.</p> <p>4 Is your understanding that a child is more likely to 5 disclose being a victim of harmful sexual behaviour than 6 being a victim of abuse by an adult?</p> <p>7 A. More likely to disclose? No, that's not my 8 understanding at all. I mean, in fact, as awareness on 9 the issue of harmful sexual behaviour perpetrated by 10 children and young people is a relatively new phenomenon 11 that's acknowledged and recognised, I think that it's 12 probably the other way, it's probably less likely that 13 children will feel confident in disclosing this form of 14 abuse as opposed to adult-perpetrated abuse. For 15 example, many of the public education campaigns that 16 have existed over the last two decades that have 17 supported children in making disclosures typically have 18 talked only about risk from adult perpetrators. So, 19 again, it's given some degree of education to children 20 about their bodies and about appropriate responses to 21 that and how they can get help if they feel that things 22 are going wrong for them and someone is harming them, 23 but actually if the examples given to them are only 24 about adults, that perhaps inhibits children's ability 25 to speak about harmful sexual behaviour by other</p> <p style="text-align: center;">Page 43</p>	<p>1 children and young people.</p> <p>2 Q. Do you think there are greater barriers to disclosure in 3 the care setting than in the domestic setting of harmful 4 sexual behaviour?</p> <p>5 A. I have talked in my report about how the care system is 6 perhaps structurally weak in relation to providing some 7 of the significant learning and evidence from studies 8 that have talked about, you know, how children disclose, 9 which are around, you know -- talk about, for instance, 10 their likelihood to disclose to trusted adult parent 11 figures, which is probably more difficult for children 12 in the looked-after system or the care system, to have 13 those kinds of consistent supports from their parents if 14 they are disconnected from them. Also, there is 15 learning that adolescents are more likely to disclose to 16 their own peers. But of course, in a care setting, if 17 the peers are those who are instrumental in harming 18 them, then that further shuts down an avenue for 19 personal support to them.</p> <p>20 So I think we would be wise to look about how we can 21 build and address those structural weaknesses by 22 offering other opportunities for children, other 23 supports for children, to disclose.</p> <p>24 Q. I suspect I know your answer to this, but just to be 25 clear, do you have any understanding as to whether the</p> <p style="text-align: center;">Page 44</p>

1 barriers to disclosure of harmful sexual behaviour have
 2 reduced in the last few decades?
 3 **A. I think the broader awareness that children and young**
 4 **people now have about the existence of sexual abuse has**
 5 **been helpful in setting a context in which they are more**
 6 **likely to be able to understand their experiences of**
 7 **abuse, but of course I refer back to what I said a few**
 8 **moments ago about how that may be less significant in**
 9 **relation to this particular issue. So I think we have**
 10 **a job of work to do in terms of educating children more**
 11 **generally about this particular issue.**
 12 Q. Is there any research that you know of as to whether
 13 a child who has been sexually abused by a peer is more
 14 likely to be sexually abused by other children within
 15 the same placement?
 16 **A. I think there is evidence and understanding now that in**
 17 **group -- that's also been endorsed by the Australian**
 18 **Royal Commission recent report, that children who are**
 19 **abused by peers are more likely to be abused in peer**
 20 **group contexts rather than a one-to-one context, as is**
 21 **more prevalent in relation to adult-perpetrated sexual**
 22 **abuse. So I think that this highlights the importance**
 23 **of looking at peer group contacts -- sorry, I forgot**
 24 **your question as I'm halfway through my answer.**
 25 Q. It is whether children who have been abused by a peer in

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1 **A. I think if one of the consequences of being exposed to**
 2 **sexual abuse is traumatic sexualisation, as Finkelhor**
 3 **and colleagues have said, is a key impact area, then,**
 4 **yes, within that, that may make it more likely for that**
 5 **child in a care context to replicate the dynamics of**
 6 **what their experience has been in relation to adults**
 7 **with peers around them.**
 8 Q. Finally, Professor Hackett, pages 74 to 75. You set out
 9 some of the key ways in which you think adults can
 10 enable children in care to disclose abuse. At
 11 paragraph 8.25, you discuss the need to invite children
 12 to talk about their experiences on the basis that they
 13 are not very likely to spontaneously disclose. How can
 14 this be done without risking leading a child into
 15 disclosure?
 16 **A. I think if there's a culture within a care setting of**
 17 **talking to children about issues that affect their**
 18 **lives, and sensitive and personal issues, if there's**
 19 **a system that includes discussion around experiences of**
 20 **sex, that perhaps then provides a framework that gives**
 21 **permission for children to talk about sexual matters,**
 22 **including harmful sexual behaviours and experiences of**
 23 **abuse. In other words, setting that broader context may**
 24 **not then be leading a child into a disclosure, but just**
 25 **giving permission that, actually, the sexual aspect of**

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1 a care setting are then more likely to be abused by
 2 others?
 3 **A. I think if we take into account that point about peer**
 4 **group context, then obviously one experience of harm and**
 5 **sexual harm within a peer group context may then**
 6 **predispose a kind of chain effect, particularly if there**
 7 **are group dynamics. So yes.**
 8 Q. Is there any research on whether that child who is
 9 abused by peers is then more likely to be abused by
 10 a carer in a setting?
 11 **A. I think there is some evidence from other inquiries that**
 12 **adult perpetrators of sexual abuse are able to and can**
 13 **very quickly prey upon vulnerable children, particularly**
 14 **those who have themselves been engaging in harmful**
 15 **sexual behaviour towards other children, as a way of**
 16 **silencing them. So I think that some adult perpetrators**
 17 **are very able to pick out those vulnerabilities and use**
 18 **the dynamics of sexual behaviour between children as**
 19 **a way of actually coercing that child into further abuse**
 20 **and maybe then silencing them.**
 21 Q. Again, research going on a slightly -- on a variation,
 22 an unhappy variation of that theme, so a child exposed
 23 to abuse by a carer in a care setting, is that same
 24 child more likely to be exposed to abuse by his or her
 25 peers?

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1 **their lives is something that is of importance and would**
 2 **fall within the boundaries and remits of professionals**
 3 **in their guidance of young people.**
 4 Q. Do you think staff, care staff and foster carers, are
 5 sufficiently well trained and versed in that as at
 6 today?
 7 **A. I think we probably could do more to help professionals**
 8 **across the board to develop approaches and a language**
 9 **that would enable that. Many professionals, as indeed**
 10 **many parents, are embarrassed to talk to children and**
 11 **young people about sex.**
 12 MR SADD: Professor Hackett, thank you so much for your
 13 time. It may be that the panel have questions. Chair,
 14 I am very conscious that I have gone beyond the time,
 15 but I was very reluctant to break this evidence.
 16 THE CHAIR: No. Thank you, Professor Hackett, we don't have
 17 any questions. Thank you for your very comprehensive
 18 presentation to us.
 19 **A. Thank you.**
 20 **(The witness withdrew)**
 21 MR SADD: Chair, shall we come back at 11.35 am?
 22 THE CHAIR: Yes, thank you.
 23 (11.18 am)
 24 (A short break)
 25 (11.41 am)

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<p>1 Submissions by MR SADD 2 MR SADD: Chair, I wonder if I might ask the witness to sit 3 down for a moment, because there are one or two 4 observations I want to make to you and the panel, if 5 I may. 6 Chair, there are two things that I wish to address 7 you on, and one is of general note and one is of 8 specific note. The general note is in relation to the 9 series of corporate witnesses that we are going to hear 10 from hereon in. It is important for me to state that 11 some documents have been provided over the last day or 12 two, and they arise from rule 10 questions from core 13 participants. Chair, it is just to say this: if the 14 witness hasn't had an opportunity to consider those 15 documents in full, they can follow up in writing their 16 response to those documents. 17 The specific issue is in relation to one particular 18 statement that has been disclosed very recently, as 19 recently as yesterday, and it is in relation to a third 20 statement provided by this witness that the inquiry is 21 about to hear from, Alison Michalska, and the fact that 22 it's a statement of some length and deals with very 23 specific issues in relation to issues that have come up 24 through the course of the inquiry. 25 The inquiry's view is that responding to that</p> <p style="text-align: center;">Page 49</p>	<p>1 statement can be done in writing if there are 2 submissions that need to be made to that statement. 3 That can be done in writing and provided to the inquiry. 4 Chair, that's all I want to say on that matter. 5 I know that when questions come to be asked of this 6 witness, I think both Ms Gallagher and Mr Simblet will 7 want to say one or two words about that at the time that 8 they ask questions. 9 I'm told that the timing should be at this stage, so 10 I know Ms Gallagher wants to simply have on record an 11 issue for you. 12 THE CHAIR: Ms Gallagher? 13 Submissions by MS GALLAGHER 14 MS GALLAGHER: Thank you, chair and panel. We are very 15 conscious of the time pressures today, so I will be 16 brief. We of course can respond to the statement in 17 writing, but I need to put on record, it was circulated 18 to us, the core participants, at 10.37 this morning, 19 during the course of the first witness's evidence. 20 I wasn't using my laptop at the time. I got to see that 21 there was a statement during the very short break. It 22 has caused real distress and panic, frankly, amongst 23 many of the victims and survivors, receiving it in this 24 way at this time. 25 From a very brief look -- I haven't yet had a chance</p> <p style="text-align: center;">Page 50</p>
<p>1 to look at it in detail -- I can see much of it relates 2 specifically to one of my clients, D6, who is here and 3 who is presumably now going to hear a fulsome apology in 4 relation to matters set out in this document which his 5 lawyers haven't got to read and he hasn't got to read. 6 We are conscious we get to put brief questions to the 7 witness later, but, as you know, under rule 10, the 8 format is they are very fixed, we don't get to ask 9 follow-up questions. We cannot deal with this material. 10 I need to put on record there is great dissatisfaction 11 at this eleventh-hour, hurtful and shoddy approach to 12 giving witness evidence. These are not topics which 13 have just emerged in the last few days. Much of this 14 relates to matters which arose in week 1. There is no 15 excuse for it. I am asked by my clients to put on 16 record we are extremely unhappy with this approach by 17 the city council. 18 THE CHAIR: Mr Simblet? 19 Submissions by MR SIMBLET 20 MR SIMBLET: Madam, we are in exactly the same position. In 21 fact, there are three people whom we represent that 22 specific things relate to in this statement. Some of 23 them purport to be some sort of apology to them. It is 24 hardly much of an apology if they are not even aware it 25 is going to be said, let alone be given the opportunity</p> <p style="text-align: center;">Page 51</p>	<p>1 to be here or to watch it or to take themselves off from 2 their work, which directly affects one, and one of our 3 clients does not even know that this is to be said 4 because it came around this morning. It is not how an 5 inquiry of this sort should be conducted and it is not 6 how an institution such as Nottingham City Council 7 should conduct itself. 8 THE CHAIR: Mr Ford? 9 Submissions by MR FORD 10 MR FORD: Chair, the statement was lodged with the inquiry 11 yesterday morning. Its purpose is to give core 12 participants some notice of the evidence that the 13 witness will give. We are sorry it's late, but it does 14 arise largely out of material that we were only told 15 this witness would be asked about within the very recent 16 past. It's better, we submit, for them to have that 17 witness statement than to not have it, but we are sorry 18 it wasn't disclosed yesterday. Thank you. 19 THE CHAIR: Thank you, Mr Ford. I fully understand the 20 positions articulated by Ms Gallagher and Mr Simblet and 21 this is indeed a very unsatisfactory position, and any 22 outstanding matters will need to be dealt with in 23 writing. Thank you for your comments. 24 MR SADD: Chair, you are now going to hear evidence from 25 Alison Michalska. Her statement is at NCC003691.</p> <p style="text-align: center;">Page 52</p>

<p>1 MS ALISON MICHALSKA (sworn) 2 Examination by MR SADD 3 MR SADD: Ms Michalska, you have provided three statements 4 to the inquiry. The first statement, dated 5 20 July 2018, runs to 105 pages, and that is, as I have 6 just given the reference, NCC003691. The second 7 statement you have provided to the inquiry is three 8 pages and is dated 11 October 2018 and that's NCC003802. 9 The third statement, NCC003807, runs to 12 pages, and 10 it's dated 24 October 2018. Each of those statements 11 I think you have signed. Is that right? 12 A. That's right, yes. 13 Q. At the time of signing these statements, were you 14 satisfied that what was set out there was the truth, as 15 far as you can remember? 16 A. That's right, yes. 17 Q. Do you have any corrections that you want to make to any 18 of those statements? 19 A. There are two minor corrections to the first statement. 20 The first is on page 89 in 7.85. There is a number in 21 there of 35. That's incorrect. It should be 38. On 22 page 104, under the heading "Quality assurance", there's 23 a comment saying "historical quality assurance which 24 were our briefing notes". That shouldn't be there. 25 Q. I don't propose, Ms Michalska, to go through your</p> <p style="text-align: center;">Page 53</p>	<p>1 statements line by line. I'm going to explore with you 2 certain topics to which you have been alerted. I may 3 have to move from one topic quite swiftly to another, 4 bearing in mind that, at the end of my questions, two of 5 the core participants' representatives are also going to 6 be asking you questions. You are presently corporate 7 director for children and adult services, Nottingham 8 City Council, and you have been since 2013? 9 A. That's right. 10 Q. Before that, you have held various posts in 11 Social Services, one of which at one point was with 12 Nottinghamshire; is that right? 13 A. Yes. 14 Q. What was that post? 15 A. I was an assistant director for adult services between 16 2000 and 2003. 17 Q. We are first going to look at the approach to 18 contemporaneous allegations. I want to explore a couple 19 of matters. Can we turn, please, to page 36 of your 20 first statement. 21 Under "Current position". Do you have that? 22 A. Yes. 23 Q. At 3.136 you set out details of how and on what basis 24 issues concerning child sexual abuse would be escalated. 25 If we move forward two pages, at paragraph 3.139 -- do</p> <p style="text-align: center;">Page 54</p>
<p>1 you have that? 2 A. I do, yes. 3 Q. You state that serious incidents involving children in 4 the community or in care are escalated using an internal 5 process that is known as "notifiable incident process"? 6 A. Yes. 7 Q. In what circumstances, please, would a notifiable 8 incident, including allegations of sexual abuse, be 9 reported to you? 10 A. So any allegations that would be around sexual abuse 11 that involved child-on-child abuse of children in our 12 care or where the allegation was that somebody in 13 a position of trust had abused the child, so be that 14 a teacher in one of our schools, a worker in one of our, 15 say, children's homes or a foster carer. So anyone 16 around a position of trust. 17 What it wouldn't do, to be clear, is notify me of 18 allegations of abuse that were familial abuse, unless 19 they were so extreme that it was felt that I needed to 20 know the case details. 21 Q. What is the threshold, Ms Michalska, of severity for 22 escalating an incident to the city's chief executive? 23 A. The chief executive would get these pretty much the same 24 instances as I would, to be honest. So something 25 involving a member of staff, something involving</p> <p style="text-align: center;">Page 55</p>	<p>1 a public figure, somebody who would be likely to be 2 known to him, something involving a person employed by 3 the city council. Indeed, that would be employed wider 4 than Children's Services. 5 Q. So he would be told in parallel with you? 6 A. He would, yes. 7 Q. Once an allegation is reported to you, Ms Michalska, 8 would you expect to be kept informed of the outcome of 9 any strategy meetings? 10 A. Absolutely, yes, so the notifiable form -- there's an 11 original one that he's done and then actually there are 12 then updates sent when there's either been a strategy 13 meeting or something of significance and it's 14 recirculated around, so yes, I am kept -- 15 Q. Are you satisfied that this happens in practice? 16 A. Yes, I am. 17 Q. What makes you satisfied that it does? 18 A. By the fact that actually notifiable incidents come to 19 me. I will discuss them in my one-to-one meetings with 20 Helen Blackman, who you have heard before, or Nick Lee, 21 who is my director in education, science and services, 22 because clearly some are originated in that part of my 23 service. So, yes, I'm as confident as any director 24 could be that I am kept appropriately informed. 25 Q. You state at paragraph 3.141, please, that there is</p> <p style="text-align: center;">Page 56</p>

<p>1 a requirement that members of staff who become aware of 2 an allegation of abuse against someone working with 3 children must report it to the local authority 4 designated officer as well as their line manager. 5 A. Yes. 6 Q. Is there any direct liaison between you personally and 7 the LADO in that process? 8 A. No. We are based all in the same office, it is a big 9 open-plan office. I do have conversations with the 10 LADO. They will come and find me if they are 11 particularly concerned. But that would typically come 12 through the management chain of the organisation. 13 Q. Page 39, please, paragraph 3.143. You said that in 14 addition to the internal systems which you have 15 described, there are two external systems used to report 16 high-profile issues. 17 A. Yes. 18 Q. In that paragraph, you also state that the Children's 19 Homes Regulations require the registered manager to 20 notify Ofsted. In the last paragraph at the bottom of 21 page 39, you state that the council don't keep a central 22 record of these notifications, which I think refers to 23 the Ofsted notifications? 24 A. That's right. 25 Q. But that in sexual abuse cases, there would be</p> <p style="text-align: center;">Page 57</p>	<p>1 a detailed record on the child's file? 2 A. Yes. 3 Q. Have I understood that correctly? 4 A. That is right, but, actually, from preparing for the 5 inquiry and since this was written, two things are 6 happening. We are having a review of our internal 7 notifiable incidents, not least because, because of 8 the Children's Homes Regulations, it's called 9 a notifiable to Ofsted, there are sometimes confusions, 10 so we are actually looking to change our internal 11 process and not least to give it a different title so 12 there isn't those confusions, and also I have asked that 13 we do keep a central record of those notifiable 14 incidents going to Ofsted. 15 Q. So to date, in the absence of any central record, how 16 has compliance with Ofsted notifications been monitored? 17 A. It's monitored through the service manager and the head 18 of service responsible for that service, and, again, 19 it's something that we are very confident does happen. 20 Q. Monitored in what way? 21 A. So all the notifiable reports are signed off by the 22 service manager responsible for our residential 23 services, and then they are then reported through under 24 Ms Blackman's line management. 25 Q. Are there circumstances, Ms Michalska, where the</p> <p style="text-align: center;">Page 58</p>
<p>1 reporting duty is triggered but where Child Protection 2 Conferences are not convened? 3 A. So I think we need to be clear. Where there are 4 children that are in our care and they will be subject 5 to a care order and a care plan, so we wouldn't normally 6 do a section 47 or child protection because the 7 statutory requirements would be that actually that 8 single plan would be reviewed and refreshed. But 9 absolutely there would be strategy meetings and there 10 will be -- you know, the incidents will be very 11 seriously looked into. 12 Q. Should the inquiry assume that all such incidents are 13 provided or have a separate record? 14 A. They will be recorded on the child's file. So we are 15 very clear that actually -- this has been some of 16 the challenges of finding, at times, types of incidents 17 that are not necessarily recorded separately. It's 18 really important that the records are kept on the 19 child's file, so we have a single record about the 20 child. 21 Q. But the inquiry's understanding on the basis of your 22 evidence this morning is that, to date, and until what 23 you have just told the inquiry, there is no central 24 record of how many allegations of sexual abuse of 25 children in care have occurred?</p> <p style="text-align: center;">Page 59</p>	<p>1 A. Yes, that's correct, yes. 2 Q. I want to turn next to look with you at two 3 contemporaneous cases, those of L43 and of D6. You have 4 provided a third witness statement in which you discuss 5 the issues relating to these cases to some extent. In 6 relation to L43, as you will be aware, L43, or NO-A103, 7 was placed at Beechwood in 2002 -- 8 A. Yes. 9 Q. -- and was in the care of the city council. Whilst at 10 Beechwood, L43 was subjected to sexual abuse by another 11 resident. The assaults were reported to the police, but 12 the other resident remained at the home in the immediate 13 aftermath. 14 A. That's right. 15 Q. Do you accept that this was contrary to advised practice 16 and policy at the time? 17 A. Well, obviously I wasn't around, so I'm relying on the 18 records and obviously the testaments of people who were 19 around at the time. 20 Q. But you will have been advised, Ms Michalska -- sorry to 21 interrupt you. You no doubt are au fait with the 22 policies that were in existence at the time? 23 A. Yes. 24 Q. And you have no doubt had the opportunity to compare 25 those policies with the actions taken at the time?</p> <p style="text-align: center;">Page 60</p>

<p>1 A. Yes. 2 Q. Do you agree that this was contrary to advised practice 3 and policy at the time? 4 A. I do, yes. Yes, I absolutely agree, yes. 5 Q. At a 2002 strategy meeting which took place following 6 the incident, which you have behind tab 27 of your 7 bundle, but we don't need to go to it, it was noted that 8 L43 "was regularly targeted" by other residents as 9 a result of his "provocative behaviour". What more do 10 you think the city council could, and should, have done 11 to protect L43? 12 A. I think that, in any case like this, our preference 13 would always be to try and move the perpetrators of 14 abuse and, you know, people who have been – children in 15 our care will have typically been subject to certainly 16 abuse or very difficult and challenging circumstances as 17 to why they came into care. That does also include, 18 therefore, those children that go on to harm others when 19 they are in care. They are also damaged and disturbed 20 individuals and we need to ensure that we meet their 21 needs as well. But our preference, if we are going to 22 move any child, if we cannot keep those children safely 23 together, our preference would be to move the child who 24 was the perpetrator and to try and keep as much 25 stability for the victim as possible.</p> <p style="text-align: center;">Page 61</p>	<p>1 There may be times that the victim actually would be 2 the one who wanted to move, and most importantly now we 3 clearly listen to the child in terms of what their 4 wishes would be. 5 Q. As you know, L43 alleges that he was pressurised by 6 NO-F1 to drop his criminal complaint. 7 A. Yes. 8 Q. He was threatened that if he continued with the 9 complaint, he would be moved to a children's home far 10 away from his family. You say at paragraph 2.1 of your 11 third statement that NO-F1 was dismissed for reasons 12 unconnected with this issue by the city council 13 in May 2011. I am asked to ask you, do you consider 14 that there were missed opportunities in the council's 15 handling of allegations against NO-F1, given that he was 16 not dismissed until 2011? 17 A. Absolutely. What I don't know is whether – what has 18 been emerged about him putting wholly and utterly 19 dreadful pressure on L43 not to press charges was just 20 absolutely devastating. If that had been known at the 21 time, then clearly, if that were happening now, that 22 individual member of staff would be removed immediately. 23 That was outrageous. 24 Q. I want to look, please, at the case of D6. D6's 25 evidence to the inquiry is at tab 34 of your bundle. As</p> <p style="text-align: center;">Page 62</p>
<p>1 you know, D6 was placed in foster care in the mid 2000s. 2 A. Yes. 3 Q. Whilst D6 remained in the care of the city council, 4 initially his foster family were living in Yorkshire 5 before moving to the Isle of Wight? 6 A. Mmm. 7 Q. You discuss various issues arising from D6's case at 8 paragraph 3 of your third statement. I want to pick up 9 on one issue. D6 addressed in his evidence the nature 10 of care meetings with Social Services. He said: 11 "The current setup with foster placement involves 12 a lot of people, so the child has a social worker, you 13 have the carers, those carers have a social worker, you 14 have two line managers, a reviewing officer, 15 a representative from the school, and often the meetings 16 were conducted in such a way that you had to be present 17 but you're talked around. You're not recognised as 18 a sentient being. Decisions are made for you without -- 19 usually without including you in the process". 20 Ms Michalska, have any steps been taken to ensure 21 that the experience of children attending care meetings 22 today doesn't match that of D6? 23 A. Absolutely, yes. There are huge improvements and that 24 will be, I'm sure, of no comfort to D6. I absolutely -- 25 I would want to offer my heartfelt and sincere apologies</p> <p style="text-align: center;">Page 63</p>	<p>1 too. The care that he received, in so many ways, was 2 just truly shocking and dreadful. But now absolutely we 3 ensure that young people -- there's a range of tools, 4 including we use MOMO, which is an app, Mind of my Own; 5 the independent reviewing officer will take the time to 6 talk to the child alone beforehand to try and get their 7 views. Young people are of course invited to be an 8 absolute central part of their review. Some choose not 9 to be and therefore we make sure that their views are 10 heard through their social worker, through the 11 independent reviewing officer or through an independent 12 advocate, however they would choose. 13 We also -- one of the other things that's made a big 14 difference is we ensure that minutes are written in such 15 a way that absolutely the child is the centre of that 16 and they're written in a child-friendly way, appropriate 17 to the age of the young person. So, you know, I'm 18 pleased to say it is very, very different. That doesn't 19 in any way detract from how poor it was in the past. 20 Q. At paragraph 3.2 of that third statement, you describe 21 the fact that there were periods when D6 was not visited 22 as often as he should have been, and indeed he gave 23 evidence to that effect. You say that there were points 24 at which there were "significant staffing challenges" 25 which impacted on the frequency of his visits he</p> <p style="text-align: center;">Page 64</p>

1 received. You say, "I highlight this to explain, not
 2 excuse, our approach. It quite simply should not have
 3 happened".
 4 Ms Michalska, are there measures now in place to
 5 ensure that the care of children is not compromised in
 6 the case of staffing challenges?
 7 **A. Absolutely, yes.**
 8 **Q. What are those measures?**
 9 **A. Well, there's a whole range of things, and probably time**
 10 **doesn't allow me to go into all of them. I think the**
 11 **most important thing has been our approach to the**
 12 **recruitment and retention of social workers, so the**
 13 **position that at the time when there were many staff**
 14 **shortages, and in more recent history we have had – we**
 15 **have relied heavily on agency staff. I'm really pleased**
 16 **to say that our recruitment and retention of social**
 17 **workers has been very successful. We now have some of**
 18 **the lowest turnover of social workers in the country and**
 19 **our reliance on agency workers has reduced from**
 20 **21 per cent down to 8 per cent. So we have a far more**
 21 **stable and consistent workforce.**
 22 **Another really significant change is that following**
 23 **the inspection in 2014, we commissioned a different and**
 24 **much, much better IT system to support our social**
 25 **workers and our practice. One of the things that we**

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1 **A. Yes.**
 2 **Q. We heard that this assists with accessing childcare**
 3 **records relating to complainants, helps with producing**
 4 **chronologies to assist police investigations, produces**
 5 **reports for strategy meetings and offers support to**
 6 **complainants. Is it right that the city has no**
 7 **equivalent to the county's historic abuse team?**
 8 **A. It's right we don't have a historical abuse team –**
 9 **Q. Why is that?**
 10 **A. My personal view is that actually the historical abuse**
 11 **team is not the right approach, and I'd like, if I have**
 12 **time, please, to explain very briefly why that is.**
 13 **First and foremost, in terms of the police accessing the**
 14 **records, the city council's approach in conjunction with**
 15 **the police is that the police come in and have full**
 16 **access to our childcare records. Because I do not think**
 17 **it is appropriate that the social worker sifts through**
 18 **the file and decides what is or isn't relevant to**
 19 **a police investigation. That, for me, and I think in**
 20 **law, is actually a matter for the investigating officer.**
 21 **So Nottinghamshire Police have their access to all of**
 22 **the records that we would have about a child, be that**
 23 **a current case or an historical case, and they come and**
 24 **access our files.**
 25 **Secondly – and I realise that this is a different**

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1 **commissioned bespoke to this Liquidlogic recording**
 2 **system is actually for independent reviewing officers to**
 3 **actually record their interaction with children in**
 4 **between reviews to ensure that their reviews are seen,**
 5 **but also one of the very important things that it does**
 6 **is, it captures every visit that a social worker makes**
 7 **to a child. It captures whether the child is seen**
 8 **alone. It captures the frequency of those visits. It**
 9 **captures whether reviews and visits are held within**
 10 **schedule and on time. And we consider that the**
 11 **statutory requirements for visiting children in compare**
 12 **is a minimum that we will adhere to and, in fact, we**
 13 **actually – many of our children are visited far more**
 14 **frequently and far more in line with their wishes as to**
 15 **when they would want to be visited and how they would**
 16 **want that to happen.**
 17 **Q. So is your evidence to the inquiry that, as at today's**
 18 **date, you are satisfied that the city council social**
 19 **workers are visiting children in foster placements on**
 20 **a regular and frequent basis?**
 21 **A. I am, yes.**
 22 **Q. I want to turn next, please, to the city's approach to**
 23 **dealing with non-recent allegations. On Tuesday of this**
 24 **week, the inquiry heard from witnesses about the**
 25 **county's historical abuse team?**

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1 **position for myself than it is for my colleague,**
 2 **Mr Pettigrew, in the county council – is that I am also**
 3 **responsible for adult services and I genuinely believe**
 4 **that support to victims of non-recent abuse who are then**
 5 **by their very nature adults need the advice and support**
 6 **from skilled adult social workers and adult specialists.**
 7 **I'm responsible for adult specialists. There's been**
 8 **reference made by survivors very positively to**
 9 **Helen Jones, who is the director of adult services, who**
 10 **worked for me, who has recently moved on to Derbyshire.**
 11 **It is really important that Helen and her team are**
 12 **supporting adult victims. They are very aware and their**
 13 **social workers and mental health workers work with**
 14 **colleagues across health and other mental health**
 15 **services who are specialists in dealing with adults who**
 16 **were a victim of sexual and harmful abuse as children.**
 17 **They are the right people. I do not believe that**
 18 **children's social workers are the right people to be**
 19 **supporting adults.**
 20 **What we have importantly in terms of when the**
 21 **allegations, be it through a civil claim route or**
 22 **whatever route an allegation would come to us, they are**
 23 **directed to a single point of access within our children**
 24 **and families direct services, which is where our MASH**
 25 **sits and our front door and single point of access into**

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1 a whole host of services.
 2 That was why -- again, this was picked up yesterday
 3 by Ms Coupland -- when I was asked by a person to give
 4 some help and support to her son who had been a victim
 5 of abuse as a child, I put her in touch with that single
 6 point of access, because that is the gateway in, not
 7 just to the city council's services, but to health
 8 services, to adult services, to children's services.
 9 Q. Listening to your response, should the inquiry
 10 understand that you have taken a lead on this?
 11 A. Absolutely. 100 per cent.
 12 Q. So you are directly involved?
 13 A. Directly involved.
 14 Q. How often do you review to see or evaluate how
 15 successful the approach you are taking is?
 16 A. It really is a point of constant review, to be perfectly
 17 honest. So my colleague who works for me, a gentleman
 18 called Will Hose, he has been that single point of
 19 access. He and I -- to be honest, we see each other on
 20 a daily basis. He sits just at the other end of an
 21 open-plan office to me. He will come and talk to me if
 22 he has any concerns. But the performance reporting
 23 around that comes through our monthly reporting board
 24 but it also reports into the strategic management group
 25 that I established when I joined the city council which

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1 much around just capturing, from the LADO's point of
 2 view, the relative merits of the allegations received.
 3 It's an awful letter. The author of that letter -- it
 4 is a standard letter that is filled in by the LADO. The
 5 author wishes me to pass on her apologies to the
 6 particular person and indeed anyone else who has
 7 received them --
 8 Q. Ms Michalska, can I interrupt you? The nature of
 9 the letter to the recipient is indeed very important and
 10 has the potential, as indeed this witness describes, of
 11 affecting them.
 12 A. Yes.
 13 Q. At what point was any thought given to how that
 14 pro forma letter which you describe ought to be changed?
 15 A. Being perfectly honest, no thought was given to that
 16 until this complaint. What I'm pleased to say, although
 17 it doesn't help this particular person at all, nor
 18 anybody that's received a letter in the past, but will
 19 in the future, is that we now have actually recruited
 20 somebody to put together not only just to deal with that
 21 in a very different way, but will also offer anybody who
 22 is going to receive that letter -- well, receive the
 23 information, it won't be a letter in that way, to have
 24 the opportunity for someone to come and visit them at
 25 home or for them to come in and we will go through the

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1 oversees the work of Operation Equinox. So not just
 2 from a city council point of view, but the city, the
 3 county, the police and our health colleagues all working
 4 together.
 5 Q. A number of survivors, Ms Michalska, have described how
 6 they have received letters from the Nottingham City
 7 Safeguarding Children Board which had provided without
 8 context a list of allegations which had been
 9 substantiated and a list of those considered
 10 unsubstantiated by the strategy panel. L48/A51,
 11 received one such letter. The letter, which we don't
 12 need to turn up, simply set out the allegations which
 13 had been considered substantiated and those which had
 14 not, and stated in the case of the latter that
 15 insufficient corroborative evidence had been found to
 16 support the claims but this was not to say that the
 17 allegations were not believed.
 18 Why are the strategy meetings convened without
 19 complainants being notified or invited?
 20 A. So that is -- it essentially is a real hangover from
 21 historical allegations -- allegations of abuse
 22 management system I think it was called, sorry, the
 23 initials -- it is in that part of, I think, my statement
 24 that refers to that. That was an old system that
 25 actually is no longer a requirement, and that was very

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1 findings of that.
 2 Q. Why is it that conclusions are reached about allegations
 3 without input from the complainant about whom the
 4 meeting is conducted?
 5 A. I can't answer that, to be honest, other than the fact
 6 that doesn't seem to be a very fulsome way of doing so.
 7 I can only assume that the LADO takes it from the
 8 presenting information, so I'm sorry that feels very
 9 unsatisfactory.
 10 Q. L48 and other complainants have described the distress
 11 that they experienced in being informed of the board's
 12 conclusions regarding allegations without being provided
 13 with any rationale for the decision. At paragraph 4.4
 14 of your third statement, you say:
 15 "Moving forwards, all survivors of non-recent abuse
 16 will be offered the opportunity to meet with someone
 17 senior from the city council to discuss the outcome
 18 letter they have received, should they wish."
 19 A. That's right.
 20 Q. At such meetings, Ms Michalska, will complainants be
 21 provided with an explanation of the rationale for the
 22 conclusions arrived at by the board?
 23 A. That is exactly the purpose of that meeting, and to both
 24 receive it in a way that hopefully is more conducive to
 25 what they would need, but also having a much fuller

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1 **explanation, and also an opportunity for them to ask**
 2 **more questions, so if they don't have sufficient**
 3 **evidence -- information, we can then go back to them.**
 4 Q. In the case of L48, are you in a position to explain to
 5 him why his allegations of sexual abuse were found to be
 6 unsubstantiated?
 7 **A. Sitting here personally now, no, I'm not. But I'm**
 8 **absolutely very happy that senior colleagues, who were**
 9 **involved in that investigation, would be very happy to**
 10 **meet with him and indeed anybody else who wants and**
 11 **deserves further explanation.**
 12 Q. The next case we are going to look at, please. The
 13 inquiry has heard from L43/A103 in the first week of
 14 the hearings. L43 discussed his experience of bringing
 15 a civil claim against the city council. He described
 16 how he found the offer from the council "insulting".
 17 Referring to the offer in his evidence to the inquiry,
 18 L43 stated:
 19 "It's like offering me a £10 note and telling me to
 20 go home and shut up. That's what it is. It's
 21 disgusting."
 22 L43's comments on the process of bringing a civil
 23 claim reflect those of many core participants whose
 24 evidence is before the inquiry. You discuss the city's
 25 approach to civil claims at paragraph 5 of your third

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1 Q. Just to pick up on what you have just said. You said
 2 a moment ago that the insurers do not play any part in
 3 the decision whether or not to defend --
 4 **A. Yes.**
 5 Q. -- or settle a claim. The first -- you then have just
 6 said to me that the first thing that happens is that the
 7 claim goes to the risk and insurance department?
 8 **A. I'm sorry, then I have confused the two things.**
 9 **I thought, when you said "do insurers", I thought you**
 10 **were relating to any external company who may have**
 11 **insured the county council against -- the city council**
 12 **against losses. They have no part in it. They might**
 13 **try and seek to influence, but I'm very clear that**
 14 **actually that, in terms of claims of this nature, the**
 15 **view of the insurers, in my view, is irrelevant. It**
 16 **might be relevant about a kerb -- you know, a raised**
 17 **kerb or something, but in terms of where we are dealing**
 18 **with things like historical abuse of children in our**
 19 **care, an insurance company, to me, has no view in that.**
 20 **We have a section in the city council called our**
 21 **risk and insurance and they are the part of the council**
 22 **that deals with a whole range of risks and assessment of**
 23 **our risks and also deals with our insurance companies**
 24 **over a whole range of different issues. So I'm sorry if**
 25 **I wasn't clear about that.**

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1 statement. To what extent, Ms Michalska, do insurers
 2 inform the city's approach to defending claims?
 3 **A. They don't, to be perfectly honest. I think that not**
 4 **just through this inquiry but since I became involved in**
 5 **looking at civil claims over the last -- the five years**
 6 **I have been working for Nottingham City, I have thought**
 7 **that the system is very adversarial, it's very clunky,**
 8 **it certainly isn't conducive, I don't think, to people**
 9 **feeling supported through that purpose. I think it is**
 10 **one of the things I would sincerely hope that either**
 11 **this inquiry or the reparations strand of the IICSA**
 12 **inquiry can seek to address. There are huge**
 13 **contradictions in terms of the way that people are able**
 14 **to access information. It is a very unwieldy and not at**
 15 **all friendly process for anyone to go through.**
 16 Q. Although I'm aware, Ms Michalska, that counsel for core
 17 participants will be returning to issues relating to
 18 civil litigation, I just want to ask you what sorts of
 19 considerations inform the city's decision about whether
 20 or not to defend a claim or try and settle it?
 21 **A. They are dealt with through our risk and insurance as**
 22 **a first point, as any civil claim would be, whatever the**
 23 **nature of it. They will --**
 24 Q. May I interrupt you there?
 25 **A. Sorry, yes.**

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1 **So our risk and insurance team, who are**
 2 **a city council team, will look at the claim in its first**
 3 **instance and they will work with social care or other --**
 4 **whatever other parts of the council might be involved,**
 5 **to try and pull together the relevant records in terms**
 6 **of assessing how we might progress this claim.**
 7 **We always want to progress them as quickly as**
 8 **possible. For all sorts of reasons, often completely**
 9 **outside the city council's control, things take a lot**
 10 **longer.**
 11 Q. The inquiry has heard evidence from a number of
 12 complainants in receipt of counselling who are concerned
 13 that their counselling will be terminated. It is
 14 understood that city council co-commissions the
 15 independent sexual adviser service?
 16 **A. That's right.**
 17 Q. Is that right?
 18 **A. Yes, that is right, yes.**
 19 Q. In addition to co-commissioning the service, what other
 20 specialist counselling does the city council provide?
 21 **A. So we commission a range of other services as well, like**
 22 **the Imara Service, which deals again with --**
 23 **specifically around sexual abuse that children suffer,**
 24 **be that familial abuse, peer-on-peer abuse or whilst in**
 25 **care, and there's a range -- a whole range of services**

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<p>1 that we commission, and then of course in our adult 2 services we have specialist workers employed directly by 3 the city council and of course our children's social 4 workers. 5 Q. Are you able to provide an assurance to victims and 6 survivors in receipt of counselling from the 7 city council that they will continue to have access to 8 such services for so long as they require it? 9 A. Yes, and I think you heard Councillor David Mellen 10 yesterday saying that, actually, children in our care 11 and victims and people who have been in our care 12 historically are our biggest priority, so absolutely. 13 But clearly, some counselling of course is better 14 provided through the health service and we will always 15 advocate that people receive that counselling if that is 16 more appropriate than something we directly commission. 17 Q. At paragraph 10.2, please, of your third statement, you 18 discuss the issue of support for A303's mother. 19 A. Yes. 20 Q. You describe how, following a meeting that took place on 21 18 September 2014, you made contact with A303's mother 22 by email, an email which we saw yesterday. 23 A. Yes. 24 Q. And that the email provided relevant contact details for 25 children and families direct. You have heard</p> <p style="text-align: center;">Page 77</p>	<p>1 Mandy Coupland's evidence on this issue. On reflection, 2 Ms Michalska, do you think you could have done more in 3 the wake of that meeting with A303's mother? 4 A. When I met A303's mother she had been at part of 5 the meeting and then she talked to me afterwards in what 6 was the very public foyer of our building. I agreed 7 I would email her so she would have my email and phone 8 number, but I would put her in touch with, as 9 I explained earlier, the right part of the council so 10 she could get the help and support she needed and advice 11 on how to access that for her son. 12 Whilst I'm a corporate director who has that 13 ultimate responsibility for children and adults and 14 public health services, that doesn't mean to say that I, 15 as an individual, am necessarily the best person to be 16 working with an individual. My role is to ensure they 17 receive the support that they need. 18 Q. At part 6 of your third statement, you deal with the 19 Historical Concerns Project. You say at paragraph 6.1 20 to 6.2 that after you became corporate director of 21 children's services, you were briefed in relation to the 22 ongoing investigation into historical abuse. You say 23 that you commissioned a project to "ensure that senior 24 management were fully apprised of the potential risks 25 presented by individuals who were or had been employed</p> <p style="text-align: center;">Page 78</p>
<p>1 by the city council". Have I got that right so far? 2 A. Absolutely, yes. 3 Q. Can I ask you, please, to turn to tab 16 of your bundle. 4 This is document NCC003708. Can we have this up on 5 screen, please? From the title, it appears this is 6 a table of employees and ex-employees who were subject 7 to allegations of, or concerns about, sexual abuse of 8 children considered as part of this project. 9 A. That's right. 10 Q. What was the purpose for the creation of this 11 spreadsheet? 12 A. So just wind back a little bit. When I first wanted 13 this piece of work doing -- because what I was conscious 14 of is that there are staff that had been taken on by the 15 city council and previously worked for the 16 county council, so they'd transferred to us at 1998, and 17 that other staff would have been recruited in the time 18 when our recruitment processes are nowhere near as 19 robust as they are now. I was concerned as well that 20 I'd seen evidence, particularly in relation to -- I'm 21 trying to remember his cipher -- 01 and 02, that really 22 concerned me. Because some of them we have touched on 23 in this inquiry, but they were matters of a similar 24 nature, where actually both of these had been raised in 25 a number of civil allegations -- sorry, civil claims and</p> <p style="text-align: center;">Page 79</p>	<p>1 in criminal allegations, particularly around physical 2 abuse, and I was concerned that, are there other staff 3 still working for us, or historically had worked for us, 4 who had now been allowed to leave under whatever 5 circumstances, who, if they were coming to jobs for the 6 city council today, we would not employ, and I was 7 uncomfortable, as a new director coming in, not knowing 8 who was in the council's workforce who might have 9 historically been a risk to a child and had been treated 10 differently or might currently be a risk to a child and 11 being employed. 12 Q. To whom was this information distributed? 13 A. The detail of it, so the unredacted version of it, was 14 distributed to myself and then my head of safeguarding, 15 who together we -- he managed the safeguarding -- the 16 LADO processes and the strategy meetings around the 17 individuals with HR colleagues and other colleagues that 18 needed to be involved. So he and I. 19 Q. So he took actions as a consequence of this? 20 A. We agreed them together, and I took the actions. 21 An anonymised version, like -- so a version of this 22 that had the definitions around the risk, the totality 23 of the number, but not the names, was shared with the 24 corporate leadership team because it was really 25 important that the whole council own this, because the</p> <p style="text-align: center;">Page 80</p>

<p>1 resultant changes to our recruitment practices affect 2 the whole council, not just children's and adult 3 services, but whether you are recruiting into leisure 4 services or whatever. So it was really important that 5 my corporate colleagues knew and understood and 6 supported this action. 7 Q. Over the course of the inquiry, Ms Michalska, we have 8 heard evidence about the issue of records and the 9 distress that victims and survivors have experienced as 10 a result of delays and failures to disclose records. 11 You discuss this issue at paragraph 7 of your third 12 statement. 13 You state at paragraph 7.5 that, in the light of 14 the experience of D6, you have agreed to establish a new 15 role dealing wholly with the provision of social care 16 records. You say that by the time the inquiry hearing 17 has ended, so presumably by the end of tomorrow, you 18 will have recruited someone to the above role? 19 A. That's right, yes, a colleague was recruited last week, 20 a new colleague. 21 Q. What do you say to Mandy Coupland's proposal that 22 independent archivists ought to be brought in to 23 urgently review and deal with the council's records? 24 A. I think we can -- I think we are slightly conflating two 25 issues here. The issues that I fully understand</p> <p style="text-align: center;">Page 81</p>	<p>1 around -- that Ms Coupland was raising and indeed I have 2 dealt with and personally met with numbers of survivors, 3 Mr Summers probably in particular, they are talking 4 about us being unable to find records that predate when 5 the city council -- the city corporation was responsible 6 for social care, so pre 1974. That was a time when -- 7 I'm sure I'm not telling you anything you don't know -- 8 the requirement actually was to destroy records, not to 9 retain records. 10 This new -- and, therefore, it isn't about -- so 11 I think it's right to say that we have found some old 12 records and not others, and that, to be honest, is by 13 chance that we have found them. So the only records we 14 have found pre 1974 were the records we were required to 15 retain, so things like, for example, the admissions 16 register and some medical records. Any other personal 17 care records have been destroyed and that is terribly 18 sad and we have invested time and effort in working with 19 individuals to try and help them piece that together. 20 What this role, though, is about is to overcome the 21 issues that D6 and others have had about access to their 22 current records and the far more recent records and of 23 course those records that now, as there have been 24 changes in legislation and the Children Act, we are 25 required to retain for much, much longer.</p> <p style="text-align: center;">Page 82</p>
<p>1 Our records now are almost wholly electronic -- 2 certainly any records we are creating now are electronic 3 records. We still have some paper records going back to 4 pre that system and what this person will do, will make 5 sure that people get the timely access to them, will 6 make sure that they are redacted in a way that is 7 appropriate, but then, importantly, will sit and talk 8 through those records, because I believe it is wholly 9 inappropriate that someone receives that record of their 10 care history and information about their family in a way 11 that is just cold and arrives through the post or 12 however they receive it. I think people should be 13 offered, and will be offered, the opportunity to sit 14 down one-to-one with somebody and go through that and be 15 supported. 16 Q. Does the city council currently have systems in place 17 which allow it to comply with its obligations -- 18 A. Absolutely. 19 Q. -- under the data protection legislation regarding the 20 processing of subject access requests within the 21 statutory timeframe? 22 A. Yes, it does. 23 Q. If so, what do you say to complainant core participants, 24 and in particular D6, who gave evidence about seeking 25 his records over a three-year period, who have routinely</p> <p style="text-align: center;">Page 83</p>	<p>1 experienced delays in obtaining records? 2 A. So I have written to D6 about trying to explain this, 3 and I realise that this is something that there were 4 mistakes, there clearly were mistakes. When the subject 5 access request was initially received, it wasn't 6 received by the right part of the council, and I can 7 only wholly apologise for that. Then, when it was 8 received, unfortunately D6 didn't provide the necessary 9 information, because one thing we require, if somebody 10 is asking for records, they do need to prove that they 11 are that person, and I'm sure you can understand why 12 that would be. 13 Then I think it was further confused -- this is one 14 of the points I said about earlier, it's very 15 confusing -- that when somebody has solicitors acting on 16 their behalf for a civil claim, actually the information 17 that they can receive through their solicitor in that 18 route is actually far more extensive. Now, some of 19 the delays around the subject access request and also 20 I think it affected the civil claims access was that 21 we -- that the solicitors representing D6 were hoping 22 that other members of his family would also give 23 permission to release their records, because on its own, 24 you will only receive a partial story. That did take 25 some while and, as I understand it, only one member of</p> <p style="text-align: center;">Page 84</p>

<p>1 the family has agreed to that. So that did contribute 2 to the delay. But in a way we were trying to get the 3 most fulsome records. I absolutely apologise for the 4 delay that was caused by the city council, but these are 5 two processes that actually inherently conflict with 6 each other and that is something I hope the inquiry can 7 help rule out for other people. It doesn't just affect 8 the city council, that will affect everybody up and down 9 the country.</p> <p>10 Q. You describe in your statement in exhibit AM9 -- this is 11 your first statement -- about the process of storing 12 files, and you say that all files from Carefirst and 13 Castle were transferred to Liquidlogic. I think that's 14 in 2001.</p> <p>15 A. That's right.</p> <p>16 Q. Does this mean that all files back to at least 2001 are 17 in electronic form?</p> <p>18 A. Yes. So Castle and Carefirst were the original 19 electronic system that was replaced following 20 recommendation from Ofsted in 2014 and the new system 21 was procured and commissioned and came into effect 22 from November 2016 and the Carefirst and Castle records 23 have been transferred onto that. So, yes, we now 24 have -- as I was saying a few moments ago, our records 25 are now wholly electronic, but there are still some</p> <p style="text-align: center;">Page 85</p>	<p>1 paper records that will predate that original electronic 2 system of the early 2000s.</p> <p>3 Q. Some of the complainant core participants have been 4 provided with only partial records, having been told 5 that city council employees overlooked to search for 6 records in Liquidlogic. Is there any reason why 7 a search of these records might have been overlooked?</p> <p>8 A. That was -- I'm afraid it was a human error, it was 9 a misunderstanding for somebody who previously worked 10 for our risk and insurance that hadn't understood that 11 we had moved over. The only records that would have 12 been missing, though, if I can go on to say, is records 13 that have been recorded after November 2016. So they're 14 the only records that would be solely on Liquidlogic.</p> <p>15 Q. In her statement to the inquiry, Mandy Coupland 16 discusses her efforts to assist one survivor, 17 Mickey Summers, access his records. She sets all that 18 out. She says she was surprised that she had been able 19 to uncover relatively easily what the city council 20 hadn't been able to uncover themselves.</p> <p>21 Do you have any comment, Ms Michalska, on why 22 Ms Coupland may have been able to locate Mr Summers' 23 records whilst the city council were unable to do so?</p> <p>24 A. So to be very clear, and I don't want to be critical of 25 Mr Summers, there were some records that were provided</p> <p style="text-align: center;">Page 86</p>
<p>1 to Mr Summers which are the only records that the 2 city council, and indeed the county council, who 3 actually had his records, were able to find. They were 4 the admissions register that said when he was in certain 5 homes on certain dates and some medical records. We 6 disclosed those to Mr Summers via email when he was 7 living in America. The records that then later 8 Mr Summers put on Facebook as saying "A friend of mine 9 has been able to find this", that I know now is 10 Ms Coupland, were the records we sent him.</p> <p>11 Q. I want to turn, please, to the issue of apologies. 12 Yesterday, I took David Mellen to the minutes of 13 a meeting of the Safeguarding Assurance Forum 14 in February 2018. The minutes are at NCC003688, and we 15 looked at them, or I looked at them, with Mr Mellen 16 yesterday. The minutes note the leader's stance 17 regarding the city council being asked to apologise?</p> <p>18 A. Yes.</p> <p>19 Q. The position being, "We will apologise when there is 20 something to apologise for". Were you involved in that 21 decision making?</p> <p>22 A. So I want to take the opportunity, really, to put a lot 23 more context around that statement, that quote, from the 24 leader and the stance of the council towards an apology. 25 The city council has always believed, and indeed we have</p> <p style="text-align: center;">Page 87</p>	<p>1 heard this, I think through the inquiry, that apologies 2 should be delivered in person to the individual 3 concerned, and I have met with individual survivors, as 4 has the leader of the city council, the leader of 5 the Opposition, the chief executive, and equivalent 6 colleagues from the county council. I have met with 7 individuals and personally apologised.</p> <p>8 In other cases, there is the case of the foster 9 carer that came to trial, although was not convicted, 10 that his victims -- senior colleagues went out to 11 support those victims, obviously to apologise to them 12 for the abuse that they suffered, or they alleged to 13 have suffered, and we absolutely believe them, at the 14 hand of their foster father and adoptive father, and we 15 apologised to those people in person. The same was true 16 of the victims of Helen Logins. They were apologised to 17 by a member of my senior staff and a senior police 18 officer, who went out to visit them and to offer them 19 support. That is our approach, whether it's the 20 approach to people who have been harmed that have been 21 the subject of a Serious Case Review or whatever the 22 circumstance: we will offer an apology individually.</p> <p>23 The leader of the council's view was more in 24 relation to making a bigger public apology. I think the 25 other thing I would want to say is that the</p> <p style="text-align: center;">Page 88</p>

<p>1 city council's website has always been clear that, had 2 people been harmed in our care, that is truly abhorrent 3 and we are generally and heartfelt very sorry. What the 4 leader of the council actually said -- and, to be fair 5 to the leader, what was said in that meeting and 6 recorded in that meeting was a very -- was a paraphrase 7 and actually really very -- it lost all the nuance 8 around it. What the leader of the council would say if 9 he were here and the conversations I have had with him 10 at length about this is, if there is an instance where 11 an employee or ex-employee or foster carer of 12 the city council is convicted in court and therefore it 13 is a matter of public record that certain people have 14 been abused, in the way it was, for example, with 15 Andris Logins or Dean Gathercole or Myriam Bamkin, that 16 actually they were previous employees of a council who 17 had been convicted, and that was very much a matter of 18 public record, he would then, as a matter of public 19 record, apologise, but his view, and I share his view in 20 many ways, is that, where that is not a matter of public 21 record, that apology should be in public -- sorry, 22 should be in private, and that actually making public 23 pronouncements around intensely private things that 24 weren't in the public domain, actually, he felt, could 25 potentially do more harm than do good. And he also</p> <p style="text-align: center;">Page 89</p>	<p>1 believed that they are -- they would be perceived as 2 just a hollow, empty statement. 3 So I think what I want to say is that I -- 4 Q. May I interrupt you, please? 5 A. Sorry, yes. 6 Q. Were you involved in the leader's approach to making 7 apologies? 8 A. I have sat down with the leader, the deputy leader and 9 the executive of the council and we have discussed this 10 together. 11 Q. So the answer to that is yes? 12 A. Yes, absolutely, yes. Yes. Absolutely. 13 Q. Was the note that we see in February 2018 in fact 14 considered following the county's apology 15 in January 2018 about which we heard evidence yesterday? 16 A. Yes. It was a direct follow-on from that, in that 17 actually the local media were asking the leader of 18 the council whether he would make an apology, and that 19 was about the public apology that I hope I've explained 20 his view. 21 Q. Should one understand that, until the county had sought 22 to make a public apology, the issue hadn't arisen in 23 discussions that you had with the leader of the -- 24 A. No, it had arisen right from my -- as soon as I began 25 working at the city council and was aware of this</p> <p style="text-align: center;">Page 90</p>
<p>1 emerging historical abuse investigation. When 2 I organised and set up the strategic management group, 3 one of the things that was a work stream of that group 4 was about communications, and not wanting -- and very 5 much working with the police, because not wanting to 6 prejudice any trials, but also wanting to make sure that 7 people were aware and actually would come forward to 8 help with evidence. But it was from the strategic 9 management group that actually on the council's website 10 was a very clear statement that it was -- had anybody 11 been abused in our care, that we were deeply sorry and 12 we would encourage them to come forward. 13 Q. June 2018, The Nottingham Post published an article 14 which is in your bundle -- 15 A. Yes. 16 Q. -- we don't need to see it -- in which you were reported 17 as having said that there was no evidence which would 18 suggest there was widespread historical abuse of 19 children in the city's care by a large number of people. 20 In your supplementary statement to the inquiry, you 21 suggest this article was not put in its proper context 22 and all you meant to do was address a very specific 23 allegation that there was a paedophile ring operating in 24 residential care in Nottinghamshire. Similarly, you are 25 reported as saying in that article:</p> <p style="text-align: center;">Page 91</p>	<p>1 "There is no evidence that I told X and they did 2 nothing about it." 3 In your second statement, you say at paragraph 1.6 4 that again the article is a misrepresentation of what 5 you said and the second half of your sentence was left 6 off, which makes clear you were referring only to the 7 fact that be there is no evidence of current staff 8 failing to act. Did you contact the editor of The Post 9 to correct that? 10 A. We didn't, no. We take the view, to be honest, that -- 11 obviously I agreed to meet with The Post and have 12 a discussion with their reporter to try and help with 13 some context in preparation for these public hearings as 14 well as updating them on the ongoing work that we are 15 doing. What I was talking about, very clearly talking 16 about, was incidents of abuse post 1998 when the 17 city council had taken back responsibility for 18 children's services. You have rightly said that the 19 first bit -- I was asked a very specific question about 20 a paedophile ring, and I think we have heard from the 21 police that their view is that there is nothing that 22 would substantiate there being a paedophile ring. And 23 the second bit was, I was talking about practice now. 24 Because what he was asking me, very sensibly, was how am 25 I assured now about -- that if something was happening</p> <p style="text-align: center;">Page 92</p>

1 **that staff would speak up and would report it, and**
 2 **you've explained, it was only a part of what I said.**
 3 Q. Do you understand why, Ms Michalska, some complainants
 4 feel that the apology finally offered by Ian Curryer on
 5 14 September 2018 and reiterated by Mr Ford QC in
 6 opening submissions is seen as both too late and not
 7 going far enough?
 8 **A. I totally accept that. We had a lot of discussion --**
 9 **the reason that it was felt appropriate at that time to**
 10 **make that public apology goes back to what the leader of**
 11 **the council's view was, and whilst there was nothing --**
 12 **you know, we haven't had a member of staff or a foster**
 13 **carer convicted, what was disclosed to us at the time**
 14 **that apology was made, so a few days before, were some**
 15 **papers that were coming to this inquiry that we hadn't**
 16 **seen, that I hadn't seen, previously that made it very**
 17 **clear that, as a city council, we were rightly going to**
 18 **be criticised in relation to Beechwood, and a lot of**
 19 **that related to the questions that you put to**
 20 **Mrs Mackechnie earlier in this process. I was very**
 21 **clear then that the city council, rightly, was going to**
 22 **be criticised for failure to close Beechwood in a timely**
 23 **way and the resultant issues that that created for**
 24 **a number of people.**
 25 **We were very aware and had long conversations about**

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1 **A. She's out and about in our homes daily.**
 2 Q. Are these reports of visits sent to you?
 3 **A. They're not sent directly to me, they're sent to**
 4 **Ms Blackman, but a digest of them comes to me and of**
 5 **course, if I want to see any of them, I can. And I also**
 6 **visit the homes myself. I would like to make that**
 7 **clear. I must say, she's an incredibly competent**
 8 **person, and somebody that Ofsted have remarked**
 9 **personally on her ability and use her as a very positive**
 10 **role model for other local authorities.**
 11 Q. Are regulation 44 visit reports sent to you?
 12 **A. The detail of them is not sent to me, no. But, again,**
 13 **I can access them, if I wish, and they are reported, as**
 14 **you know, through the proper processes.**
 15 Q. I want to look at one specific matter, please,
 16 Ms Michalska, the closure of Beechwood Children's Home.
 17 Paragraph 5.11 of your first statement. You discuss the
 18 investigation report of Bronwen Cooper?
 19 **A. Yes.**
 20 Q. The inquiry has heard evidence about the report, that
 21 the report initially contained a recommendation to close
 22 Beechwood. This was revised following a discussion with
 23 the request of Ms Mackechnie. Do you consider that the
 24 recommendation to close Beechwood in 2001 was
 25 pertinent --

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1 **the fact that the timing -- we would be criticised for**
 2 **the timing, we would be criticised for doing it -- we**
 3 **also felt we would be criticised for not doing it. So**
 4 **actually, it was a very heartfelt, very sincere apology**
 5 **and it seemed appropriate to make it. What we also said**
 6 **at the time was we were aware we were making this**
 7 **apology and we fully expect, as Councillor Mellen said,**
 8 **that in the fullness of time, when we are clear and the**
 9 **inquiry has helped us with our understanding of**
 10 **the elements that the city council have been responsible**
 11 **for, that we apologise. You know, Councillor Mellen,**
 12 **Ms Blackman and myself here, we are so sorry for anybody**
 13 **that has been harmed. Care should be about being safe.**
 14 **You know, I cannot say how sorry we are that people are**
 15 **harmed.**
 16 MR SADD: Chair, I am conscious of the fact that I have
 17 about five minutes more of questioning, and there are
 18 22 minutes of core participant questioning. In the
 19 light of that, chair, would you be prepared to sit,
 20 please, until 1.15 pm?
 21 THE CHAIR: Yes, we will do that.
 22 MR SADD: Thank you very much, chair.
 23 Looking at the oversight of residential homes,
 24 please, Ms Michalska, how often does the residential
 25 service manager visit homes?

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1 **A. Absolutely.**
 2 Q. -- given the escalating concerns at that time?
 3 **A. Absolutely. Beechwood should have been closed in 1998**
 4 **as should all of big children's homes. Our children's**
 5 **homes now have two or three children within them. They**
 6 **are like family homes. Any big institution should have**
 7 **been closed a long time ago.**
 8 Q. Does it follow from that answer that all the subsequent
 9 steps taken to address issues at Beechwood were
 10 ineffectual because that home should not have been
 11 running?
 12 **A. I think they were wholly inadequate. It had a staff**
 13 **team that, looking back with hindsight -- I don't**
 14 **personally know any of the people that worked there but**
 15 **they appeared to me to be people who didn't have the**
 16 **best interests of children, and even those who did, and**
 17 **we have heard evidence from some people who worked there**
 18 **that they were trying to do their best, but I just think**
 19 **that the style of the building, the style of the care,**
 20 **the mix of children, just was awful.**
 21 Q. We have heard evidence, Ms Michalska, about personal
 22 advisers for care leavers. Last week the inquiry heard
 23 evidence from Helen Blackman who stated there is no
 24 difficulty with personal advisers for care leavers being
 25 employed by the city council. You state at

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<p>1 paragraph 10.3 of your third witness statement that you 2 sought legal advice and that you support the views 3 expressed by Ms Blackman? 4 A. That's right. 5 Q. At paragraphs 10.4 and 10.5 you discuss two cases that 6 Ms Blackman was referred to. But notwithstanding the 7 legal position, in practical terms, are there any 8 situations in which you consider that difficulty may be 9 caused by the fact that a personal adviser is employed 10 by the city council? 11 A. I can see why there could be conflict. But this is one 12 thing -- it's the same with the independent reviewing 13 officers and personal advisers. As the law currently 14 stands, statute says that they are to be employed by the 15 council or commissioned by the council and that actually 16 the role of the director of Children's Services that 17 I have in statutory guidance it is very clear that 18 services that are -- the social work children's services 19 have to be line managed by a social worker from the 20 front-line right through to the director of Children's 21 Services. So I think that for them to be anything other 22 than employed or commissioned by local authority would 23 be contrary to that current piece of statute. 24 So there are -- there would potentially be 25 conflicts, but in the same way as there are formal</p> <p style="text-align: center;">Page 97</p>	<p>1 escalation routes, one of the things that I and 2 Ms Blackman and Councillor Mellen, as you heard, go out 3 and visit staff, we will visit our personal advisers, 4 I also have -- every month I have a session called "Meet 5 the corporate director" where colleagues, front-line 6 colleagues, come and meet with me and can talk about 7 whatever they would want to talk about. Therefore, if 8 somebody had a cause for concern, they know how to come 9 to me directly, and I am confident that they would. 10 Q. What about the situation of children who might have 11 a civil claim against the city council, but within the 12 current limitation period of that claim, so still under 13 24 -- or under 21, I should say, would a personal 14 adviser employed by the council be an appropriate person 15 to assist that young person in making decisions about 16 that? 17 A. I think a personal adviser, their role is to have the 18 young person they're supporting at the heart of 19 everything they do. If that includes bringing a claim 20 against the council, whilst we'd need to make sure they 21 weren't doing anything that then could in some way 22 conflict them personally, of course I would expect them 23 to help. But actually, what I would expect them to be 24 doing is ensuring that they are getting proper, 25 independent legal advice to be able to do that, because</p> <p style="text-align: center;">Page 98</p>
<p>1 our personal advisers, you know, they're not -- they are 2 not lawyers. 3 Q. Finally, Ms Michalska, as far as my questions are 4 concerned, the inquiry has heard evidence in relation to 5 the county council's approach to harmful sexual 6 behaviour in recent years and at present, including the 7 carrying out of an audit in October 2016 using an NSPCC 8 framework, including the formation of a Harmful Sexual 9 Behaviour Panel in January 2018 and the carrying out of 10 a harmful sexual behaviour audit in May 2018. What has 11 the city council done in the last couple of years to 12 address harmful sexual behaviour? 13 A. So the city council has been addressing harmful sexual 14 behaviour for a much longer period of time than that. 15 There have been various iterations but the current 16 arrangement is a process called ASHA and I think you 17 have had statements from somebody who was going to be 18 a witness but then was stood down around this. So what 19 the ASHA panel do, it is around the assessment of 20 harmful sexual behaviour, and it looks at both the 21 victims and perpetrators of sexual violence. 22 So in terms of the most recent statistics -- sorry, 23 I asked for this knowing I was going to be asked. 24 Excuse me just two seconds while I pull it out. In the 25 last two years, in 2016, there were less than</p> <p style="text-align: center;">Page 99</p>	<p>1 20 children with sexually harmful behaviour presented to 2 this panel. So we actually widened the scope at that 3 point to look at children and young people whose 4 behaviour could be indicative. So initially, it was 5 just those children who had already been the victim or 6 had actually sexually harmed other children. Whereas 7 actually we have now said that we need to look at 8 children whose behaviour might suggest that they would 9 go on to do that. So, for example, children who are 10 accessing pornography. In 2017 to 2018, 67 children 11 were presented to the panel and to date in 2018/19 -- 12 so to date -- 30 children have been presented to the 13 panel. 14 Some of those children actually were very young 15 children, some as young as 6 -- 16 Q. Ms Michalska, sorry to cut across you. I know it is 17 information that you are providing, but in summary, 18 would you want the inquiry to conclude that the city's 19 present approach and policy towards harmful sexual 20 behaviour of children in care is being properly 21 addressed? 22 A. I would, but can I just say, this isn't just about 23 children in care, this is all children. So these are 24 children -- actually, most of the incidents of sexual 25 harm are between siblings or children who are not in</p> <p style="text-align: center;">Page 100</p>

1 care and, of the children who are in care, the
 2 perpetrators, they have all been male and, actually,
 3 a lot of them have come into care or been remanded into
 4 care because of the sexual harm they have committed on
 5 other children. But I would be very happy to -- I think
 6 it is very good practice. It's actually been deemed as
 7 an example of best practice through the youth offending
 8 services. I'd be very happy that we provide a much
 9 fuller update in a written submission, because it is an
 10 area -- a very difficult practice, but best practice.

11 MR SADD: Ms Michalska, thank you for your patience with me.
 12 You will now be asked questions by my colleague.
 13 Examination by MS GALLAGHER
 14 MS GALLAGHER: Good morning, Ms Michalska.

15 **A. Good morning.**
 16 Q. I have received a large number of notes over the course
 17 of your evidence, and of course I can't address those
 18 with you today, but we will take up Mr Sadd's suggestion
 19 of raising them with you subsequently.

20 **A. That's fine.**
 21 Q. I say that just for those who may expect me to put these
 22 questions, which I can't, for reasons you understand?
 23 **A. Yes.**
 24 Q. I'm entitled to ask you questions on three topics which
 25 have been agreed in advance, not on these issues?

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1 **Why reputational risk is important is I need the**
 2 **public, the city council needs the public, all councils,**
 3 **or anybody providing -- well, hospitals, anybody, need**
 4 **to actually -- the public need to be confident in what**
 5 **we are doing. This was absolutely to say, "I am**
 6 **confident that there aren't people working in the**
 7 **city council who have access to vulnerable children and**
 8 **adults who have a history, a known history, of either**
 9 **potentially or actually providing a risk". So this is**
 10 **about ensuring that people can have confidence in it.**
 11 **That's not the same as seeing it in a very negative**
 12 **stance about just managing the council's reputation.**

13 Q. If we go over the page to 2.3, do you see the first
 14 bullet point which says:
 15 "Project benefits.
 16 "Children and adults are safeguarded from potential
 17 harm."
 18 **A. Absolutely.**
 19 Q. So that was central to what you were trying to do?
 20 **A. Absolutely, and that is central to our reputation. We**
 21 **need to have a reputation that children are safeguarded**
 22 **and that adults are safeguarded, and that people can**
 23 **come -- can feel -- the only way that I know a child or**
 24 **an adult is at risk is because somebody tells the**
 25 **council -- be that a member of the family, somebody**

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1 **A. Yes, that's absolutely fine.**
 2 Q. The first thing I want to ask you about concerns
 3 reputation management, an issue which has arisen with
 4 Mr Sadd. Could I have on screen, please, NCC003687_004.
 5 It is your AM68. I'm not sure where that is in your
 6 bundle but it should come up on screen. Do you see,
 7 down at the bottom of the page, there is the heading
 8 "Project objectives"?
 9 **A. Yes.**
 10 Q. Just to orient yourself, this concerns the Historical
 11 Concerns Project you commissioned in 2014?
 12 **A. Yes.**
 13 Q. Can we highlight the first bullet point:
 14 "Minimise the reputational risk to the council."
 15 Ms Michalska, a central aim of that project, indeed
 16 the first one listed here under "Project objectives" was
 17 reputation management, wasn't it?
 18 **A. Not reputation management, no. I think that's a subtle**
 19 **difference between reputational risk. What this was**
 20 **getting at was, I did not want to be the director of**
 21 **Children's Services who knowingly had somebody who had**
 22 **either been previously disciplined for harming children,**
 23 **or there had been issues of harm to children in their**
 24 **personal life, still working for me who could then go on**
 25 **and harm a child.**

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1 **themselves, a teacher, somebody working in health. They**
 2 **need to have confidence that we will deal with it.**

3 Q. Can we go back to page 4 and have the entirety of page 4
 4 on screen, just following on from that. So you have
 5 just told us that -- about the objective of children and
 6 adults being safeguarded from potential harm?
 7 **A. Yes.**
 8 Q. Do you see it has, "The project will address ..." and
 9 there is a long list of matters "in scope" and a long
 10 list of matters "out of scope". Can you just assist us
 11 with this specific issue? In the "out of scope"
 12 section, two bullet points from the bottom, where it
 13 says:
 14 "Foster carer records."
 15 If an objective of the project was to ensure that
 16 children currently in the council's care are protected
 17 properly, can you assist us with why foster carers
 18 weren't included --
 19 **A. Absolutely. Foster --**
 20 Q. -- in the scope of the review -- if I can just finish --
 21 given that most children in the city's care are
 22 currently in foster placements?
 23 **A. Because foster carers are not our employees and, in**
 24 **terms of ensuring our children are safe with foster**
 25 **carers, it's a very different process. So to be clear,**

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<p>1 our most vulnerable children in care, most of them are 2 in foster care. You are absolutely right. This was 3 about an employee's project, which is why foster carers 4 are out of scope, because they are not our employees. 5 But please don't interpret that that we are not bothered 6 about foster carers, of course we are. 7 Q. Thank you, Ms Michalska. The second issue I want to ask 8 you about is this: a central thrust of the evidence we 9 have got in writing, and indeed your evidence today in 10 relation to abuse in care, is that it's largely historic 11 and procedures and practices in children's services are 12 much better now than they were then. A kind of "That 13 was then, this is now" approach. 14 A. But -- 15 Q. Just hear me out. We have a very short amount of time 16 and I have some specific questions. We are not allowed 17 to come back when you say things back to me. We are not 18 allowed to ask follow-up questions. So just let me get 19 through the question. 20 A. Okay, fine, sure. 21 Q. Your evidence has largely been that this is historic and 22 that things are now very different. But Nottingham City 23 Council's Children's Services Department has been the 24 subject of recent criticism, hasn't it, from -- just to 25 give you a first example and I will ask you about this,</p> <p style="text-align: center;">Page 105</p>	<p>1 from Ofsted in 2017. Could we have on screen, please, 2 OFS008274 at page 2. You will see at page 1 there -- it 3 went past very quickly -- it referred to the need for 4 experiences and progress of children, the third one 5 down: 6 "... children looked after and care leavers, and 7 achieving permanence: requires improvement to be good." 8 A. That's right, yes. 9 Q. Then on page 2, under "What needs to improve" -- can you 10 see that? 11 A. Yes, of course. I'm very familiar with this. 12 Q. "Services for some children are not yet good." 13 A. Yes. 14 Q. Could you look at the third bullet point: 15 "The council does not always fully understand the 16 reasons why children go missing and therefore does not 17 always give children the help that they need." 18 Just before you comment on that, can I give you the 19 last reference on that? It is on page 4 at 20 paragraph 12, if we could highlight that. That says -- 21 A. Yes, I'm very familiar with that. 22 Q. "Staff do not consistently carry out return-home 23 interviews when children go missing, including children 24 looked after. They therefore do not explore the reasons 25 why children go missing, which limits their ability to</p> <p style="text-align: center;">Page 106</p>
<p>1 construct and implement appropriate risk management 2 plans. Managers do not oversee return home interviews 3 consistently or effectively enough." 4 This isn't historic, Ms Michalska, this is 2017. Do 5 you accept that that's a continuing obstacle to 6 identifying children who are subjected to abuse? 7 A. So two things I would say to that. Yes, that is in 8 2017. I think if you look at it in the context of 9 the previous inspection, 2014, you will see that 10 a number of the services have improved significantly. 11 Q. Not this, though? 12 A. These areas -- 13 Q. This -- 14 A. Please let me finish. 15 Q. Of course. 16 A. These areas are areas that in our own self-assessment we 17 said these were areas that, as of February 2017, we were 18 saying these areas were not yet good. Being judged as 19 "Requires improvement" means that, actually, you meet 20 all of those statutory minimum standards, but for us 21 statutory minimum standards are not good enough, and 22 these were areas that the council was in of itself 23 self-critical and actually Ofsted agreed with us. 24 So I have never said -- just to go back right to 25 originally, I've never said this is all about history</p> <p style="text-align: center;">Page 107</p>	<p>1 and this doesn't happen now, so I'm not sure where you 2 have heard that from. What I have said, I think, 3 consistently is practice is much, much better now. 4 I say that not just as the director of Children's 5 Services, but as the -- until last year, the president 6 of the Association of Directors of Children's Services. 7 That is a reflection of all of England's practice 8 towards children. There are still things that go wrong 9 and every time something goes wrong that is terribly, 10 terribly sad, but generally things are much, much 11 better. 12 Q. You accept this is an area where it's gone wrong 13 recently? 14 A. This is an area where our practice was not yet good. 15 What I will say in relation to both of those things, in 16 terms of return-to-home interviews, Councillor Mellen 17 described yesterday -- 18 Q. Could I interrupt you for a moment? The result of 19 a very, very long answer is that we won't get to ask all 20 the questions we are entitled to ask. 21 A. Sorry. 22 Q. I think I have the key point, which is you accept this 23 was a criticism in 2017? 24 A. It was our own criticism. 25 Q. And you are not suggesting that every area is perfect.</p> <p style="text-align: center;">Page 108</p>

<p>1 A. Of course not. I would be foolish to say so.</p> <p>2 Q. Can I suggest, that perhaps, rather in the way we have</p> <p>3 had to, if there is further detail to add --</p> <p>4 A. Of course.</p> <p>5 Q. -- it can be provided --</p> <p>6 A. Very happy.</p> <p>7 Q. -- in writing rather than meaning we can't ask questions</p> <p>8 which are very important --</p> <p>9 A. Very happy.</p> <p>10 Q. -- to my 45 clients?</p> <p>11 Can I give you another recent example from 2017 and</p> <p>12 this concerns the death of a child, Child J, and it is</p> <p>13 a Serious Case Review by the local Safeguarding Children</p> <p>14 Board. The reference is INQ002949. Again, this is</p> <p>15 another 2017 document, a document from last year, about</p> <p>16 the death of a 7-year-old girl.</p> <p>17 Could I ask, firstly, if we go to page 38,</p> <p>18 paragraphs 3.133 and 3.134, just for speed, that simply</p> <p>19 says that Children's Services closed the case</p> <p>20 in July 2014 and the child then died in July 2014.</p> <p>21 A. Mmm.</p> <p>22 Q. That's a case where she'd sustained physical and</p> <p>23 emotional abuse and she died of quite horrific injuries;</p> <p>24 is that right?</p> <p>25 A. That's right, yes.</p> <p style="text-align: center;">Page 109</p>	<p>1 Q. So it is not a sexual abuse case?</p> <p>2 A. No.</p> <p>3 Q. But the reason we are raising it is because it raises</p> <p>4 concerns.</p> <p>5 A. And the child wasn't in care.</p> <p>6 Q. Precisely. There are a number of matters I want to take</p> <p>7 you to that we are entitled to take you to in relation</p> <p>8 to this document. The panel will read it in full.</p> <p>9 Firstly, can I ask that we look at page 43 of</p> <p>10 the document, paragraphs 4.14 and 4.15. It may take</p> <p>11 a moment for them to come up on screen. Here in</p> <p>12 paragraph 4.14 there is a description when the child is</p> <p>13 with her aunt and being supervised by Social Services</p> <p>14 and that the aunt reports to all professionals that</p> <p>15 Child J's behaviour was unmanageable. Do you see that?</p> <p>16 A. Yes.</p> <p>17 Q. That she was self-harming, stealing and increasingly she</p> <p>18 described Child J as being deliberately naughty, defiant</p> <p>19 and unremorseful. Do you see that?</p> <p>20 A. Yes.</p> <p>21 Q. It then says "This was not sufficiently challenged</p> <p>22 directly with aunt ..."?</p> <p>23 A. That's right.</p> <p>24 Q. In paragraph 4.15, the first sentence:</p> <p>25 "Despite there being much discussion of Child J's</p> <p style="text-align: center;">Page 110</p>
<p>1 early experiences, the records and discussions suggest</p> <p>2 that child J started to be seen as a difficult and</p> <p>3 complex child by professionals."</p> <p>4 Would you accept that one of the key themes from</p> <p>5 this long document is that professionals who were seeing</p> <p>6 Child J and her aunt focused on supporting the aunt and</p> <p>7 dismissed concerns about the aunt's behaviour, on the</p> <p>8 basis that the child's behaviour was difficult?</p> <p>9 A. I think that's absolutely right. You know, we authored</p> <p>10 and contributed to a great deal of this report and, as</p> <p>11 the director of Children's Services, I have the</p> <p>12 responsibility for all the services, not necessarily</p> <p>13 directly through line managed, but the school, the</p> <p>14 health services, all of the professionals who actually</p> <p>15 were believed by the aunt rather than necessarily</p> <p>16 listening to the child.</p> <p>17 What, again, I will put back in writing to you</p> <p>18 because of time is around the significant differences</p> <p>19 and the -- the purpose of Serious Case Reviews is always</p> <p>20 to establish what is the learning. There's been a huge</p> <p>21 amount of learning following the death of this</p> <p>22 particular child in relation to physical abuse, to that</p> <p>23 challenge back to parents and the people who are</p> <p>24 supposed to be protecting this child.</p> <p>25 Q. Thank you. Just two more references in the document,</p> <p style="text-align: center;">Page 111</p>	<p>1 given time. Can we go at pages 48 to 49 to</p> <p>2 paragraphs 4.34 and 4.35, just briefly. So 4.34:</p> <p>3 "Most professionals believed she was responding to</p> <p>4 the stresses of caring for a difficult child in</p> <p>5 difficult circumstances and not being abusive."</p> <p>6 Do you see that?</p> <p>7 A. Yes.</p> <p>8 Q. Over the page, at 4.35, it says that there should have</p> <p>9 been an analysis, clear conclusion drawn from the</p> <p>10 available evidence and that simply didn't happen here.</p> <p>11 Just towards the end, four lines from the bottom, it</p> <p>12 says:</p> <p>13 "In this case, the dominance of aunt alongside</p> <p>14 ineffective multi-agency practices and a lack of a clear</p> <p>15 framework for assessing potential physical abuse meant</p> <p>16 that practice in this area was not effective and it</p> <p>17 remains uncertain what the causes of the many injuries</p> <p>18 seen were."</p> <p>19 I take it you accept that, from what you have just</p> <p>20 said?</p> <p>21 A. Completely accept it, yes.</p> <p>22 Q. There is one final point in relation to this Serious</p> <p>23 Case Review which I should raise with you, and that's at</p> <p>24 pages 63 to 65. The panel can go through it in full.</p> <p>25 But the central point, page 63, do you see the heading</p> <p style="text-align: center;">Page 112</p>

<p>1 "Lack of focus on the child and her lived experience"?</p> <p>2 A. Yes.</p> <p>3 Q. That whole section, doesn't it, criticises your</p> <p>4 department for not having a child-centric approach?</p> <p>5 A. It criticises wider than my department, but that is</p> <p>6 a criticism, yes, I accept that.</p> <p>7 Q. Do you see in paragraph 4.93 it refers to Child J being</p> <p>8 seen regularly?</p> <p>9 A. Yes.</p> <p>10 Q. So this isn't a child who wasn't being seen.</p> <p>11 A. No, no.</p> <p>12 Q. She was being seen?</p> <p>13 A. She was seen very regularly.</p> <p>14 Q. But the issues weren't picked up?</p> <p>15 A. Yes.</p> <p>16 Q. Over the page, at 4.96, importantly, do you see about</p> <p>17 halfway through the paragraph, it says:</p> <p>18 "When children make disclosures they are asking</p> <p>19 adults for help. If they are being abused, they are</p> <p>20 taking a risk, as the disclosure might lead to further</p> <p>21 abuse. It is essential that professionals handle these</p> <p>22 disclosures sensitively, that children are reassured</p> <p>23 that they [did the right thing]."</p> <p>24 Because this is a case where she had disclosed, in</p> <p>25 fact, hadn't she?</p> <p style="text-align: center;">Page 113</p>	<p>1 A. She had, yes.</p> <p>2 Q. And it wasn't dealt with appropriately?</p> <p>3 A. No.</p> <p>4 Q. And she died?</p> <p>5 A. Yes. So I think what -- as I say, we will give a much</p> <p>6 fuller response, because time doesn't allow. The areas</p> <p>7 that have been particularly picked up in this have been</p> <p>8 around looking at signs and symptoms of physical abuse,</p> <p>9 but also across the multi-agency, a significant amount</p> <p>10 of training and then follow-up audit activity to ensure</p> <p>11 that actually the child's voice is seen -- the child is</p> <p>12 seen, that the child's voice does come through records,</p> <p>13 be they social care records, health records, whatever,</p> <p>14 and we have real evidence of impact.</p> <p>15 To go back to the Ofsted report that you were</p> <p>16 quoting from earlier, it is very clear in there that</p> <p>17 Ofsted were very clear that the voice of the child is</p> <p>18 heard and is very clear in all of our records.</p> <p>19 I think the other thing that I would say that both</p> <p>20 the Serious Case Review and then the coronial process</p> <p>21 were very clear that -- obviously this was a terrible,</p> <p>22 terrible tragedy, when a child's life was taken, but</p> <p>23 that they did say that the attack that caused her to die</p> <p>24 could not have been predicted and her death could not</p> <p>25 have been predicted.</p> <p style="text-align: center;">Page 114</p>
<p>1 Q. We will also deal with that in more detail. There was</p> <p>2 another example which I wanted to give you, but I will</p> <p>3 have to deal with that tomorrow, given the time.</p> <p>4 The third topic to turn to, just very briefly,</p> <p>5 because I think I have three minutes: independent</p> <p>6 reviewing officers.</p> <p>7 A. Yes.</p> <p>8 Q. Can I just ask that we deal with two points in relation</p> <p>9 to independent reviewing officers. Firstly, we may not</p> <p>10 be able to have it on screen, but I will give the</p> <p>11 reference. You have indicated you are familiar with the</p> <p>12 2017 Ofsted review?</p> <p>13 A. Yes, of course, yes.</p> <p>14 Q. That found, didn't it, that independent reviewing</p> <p>15 officers in Nottingham City Council do not have the</p> <p>16 capacity to sufficiently monitor the progress of</p> <p>17 children's plans between review meetings, and it said</p> <p>18 that the IRO service responsible for the oversight and</p> <p>19 scrutiny of care plans does not have sufficient capacity</p> <p>20 to monitor the progress of plans in between their review</p> <p>21 meetings. It says that, doesn't it, at page 2 and</p> <p>22 pages 5 to 6 of the report?</p> <p>23 A. It does, and to come back quickly on that point, that</p> <p>24 was something we'd identified and immediately following</p> <p>25 that we increased our IRO service. We increased it by</p> <p style="text-align: center;">Page 115</p>	<p>1 one and a half staff and also they are now all employed</p> <p>2 by us, we have no agency staff in our IRO service.</p> <p>3 Q. Well, you say you had an immediate response, but this</p> <p>4 was also an area criticised in the March 2014 Ofsted</p> <p>5 report, wasn't it?</p> <p>6 A. It was, and we increased --</p> <p>7 Q. So why was there no improvement in the intervening three</p> <p>8 years?</p> <p>9 A. There was a big improvement in the intervening three</p> <p>10 years, but the demand had continued to increase, so we</p> <p>11 increased following 2014, but we'd had to have a lot of</p> <p>12 agency staff at that point. By the time we got to 2017,</p> <p>13 we had less agency staff and we increased the capacity</p> <p>14 again, and I can now say that -- well, we immediately</p> <p>15 increased it by one and a half staff, which were agency</p> <p>16 staff, but now all of the staff on our IRO team are</p> <p>17 employees. We have recently had a peer review of our --</p> <p>18 of our service that has confirmed that managers --</p> <p>19 Q. I understand that some of that may be dealt with in this</p> <p>20 new statement which I haven't yet read so it may be we</p> <p>21 have to come back to that.</p> <p>22 A. I'm not sure the detail of that is, but we are now more</p> <p>23 confident that we have sufficient capacity.</p> <p>24 Q. Just one final thing.</p> <p>25 A. Yes, sure.</p> <p style="text-align: center;">Page 116</p>

1 Q. I think I have one minute remaining. At paragraph 9.1
 2 of your statement, you state that the placement service,
 3 the IRO service and the CSE coordinator all sit
 4 together. So what does that mean? Are they in the same
 5 office?
 6 **A. We are all in the same office.**
 7 Q. Are you aware of the concerns raised by Ofsted in their
 8 2013 thematic review on IROs criticising co-location,
 9 about it potentially blurring the boundary between the
 10 Independent Review Mechanism and operational management?
 11 Are you aware of that?
 12 **A. I am aware of --**
 13 Q. Let me ask the question --
 14 **A. Sorry.**
 15 Q. -- if you from aware of it.
 16 **A. Yeah, yeah. Sure.**
 17 Q. Can you answer this: how can the IRO service effectively
 18 challenge colleagues it shares an office with?
 19 **A. So my view would be, if -- there's a similar criticism**
 20 **to say, if they are not together, then nobody ever talks**
 21 **to each other and there is a failure to communicate. I**
 22 **think that my IROs are incredibly professional. If they**
 23 **have a concern, they will challenge, they will speak up.**
 24 Q. Given the time, I think I will have to leave it here.
 25 You are aware that the House of Lords Committee on

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1 time. I'm sorry for the Countdown-style time clocking
 2 as we were doing it, but thank you and I have nothing
 3 further.
 4 Examination by MR SIMBLET
 5 MR SIMBLET: Thank you, chair.
 6 Ms Michalska, I am going to ask you about the
 7 process for dealing with civil claims. Normally, the
 8 council is notified of such a claim by a formal letter
 9 from a solicitor; is that right?
 10 **A. Yes, that's right.**
 11 Q. You have been very clear with Mr Sadd that the council's
 12 response to such letters and such claims is not affected
 13 by anything any insurance company requires you to do?
 14 **A. Yes -- well --**
 15 Q. So --
 16 **A. Let me be completely clear.**
 17 Q. Be very clear.
 18 **A. Let me be very clear. If there are certain processes**
 19 **you have to do, they will follow that. What I'm saying**
 20 **is, the decision about that claim is not impacted. So**
 21 **if an insurance company didn't want us to settle, and**
 22 **I said, "We will settle this", we will settle it.**
 23 Q. It follows, then, that the extent to which these claims
 24 are disputed is because the council is choosing to
 25 dispute them and, when they instruct lawyers to defend

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1 Adoption Reform in 2013 made a recommendation that in
 2 fact IROs should be employed outside the local
 3 authority. Do you agree with that recommendation?
 4 **A. Well, and it's interesting, really, because it was in**
 5 **the NSCB report and then there was also Martin Narey's**
 6 **review of fostering published earlier this year,**
 7 **that have made a range of recommendations, including**
 8 **Martin Narey saying that actually he felt that this**
 9 **should no longer be the role of the IRO and, in fact,**
 10 **those workers would be better deployed returning back to**
 11 **the front-line.**
 12 All I can say is, as the president of ADCS, I did
 13 respond to this, saying that it's important that there
 14 is independent scrutiny and challenge to local
 15 authorities during care planning process, and in view of
 16 the current challenges we face, actually having some
 17 more capacity at the front-line could actually be
 18 a better way forward, but that ultimately -- and I will
 19 skip to the end very quickly -- that is a decision for
 20 government, and it is something that in the response to
 21 the most recent challenge around IROs, which was
 22 Martin Narey's report, the government are not saying
 23 that they are going to do anything any different. But
 24 it isn't a matter for me as an individual --
 25 MS GALLAGHER: I have to interrupt you because that is now

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1 them, the council is choosing to do that. That must be
 2 right, mustn't it?
 3 **A. The council has to instruct lawyers to defend them; of**
 4 **course it does.**
 5 Q. The way in which the claims are defended is therefore
 6 down to the council's choice. So when somebody receives
 7 a defence not accepting that the abuse occurred and
 8 requiring them to prove it, that's because the council
 9 has required that, isn't it?
 10 **A. Well, the council does have to satisfy itself that the**
 11 **claim is a genuine claim, whatever the claim might be**
 12 **for.**
 13 Q. The same in relation to psychiatric damage: if they
 14 don't accept that the person has suffered psychiatric
 15 damage as they claim, and disputes that, and the person
 16 then has to go off and see another psychiatrist and go
 17 through this with them, that's because the council is
 18 putting them through that, isn't it?
 19 **A. I can't comment on that. I don't know the case you're**
 20 **referring to, I'm sorry.**
 21 Q. I will tell you in a moment. In relation to limitation
 22 and saying, essentially, "These all happened too long
 23 ago", that is a defence that the --
 24 **A. No.**
 25 Q. -- council is choosing to run, isn't it?

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1 **A. No. I'm sorry, that is not the case.**
 2 Q. It is the case.
 3 **A. If I can please answer, this is not my area of**
 4 **expertise. I am neither a lawyer nor any -- I don't**
 5 **work in our risk and insurance. But I can sit here and**
 6 **on oath be extremely clear that I would not accept that**
 7 **the time from when the abuse took place to when somebody**
 8 **submits a claim is in the least bit relevant. We are**
 9 **talking about historical abuse here. We are talking**
 10 **about things that people will find incredibly hard to**
 11 **talk about. We know from D6 that he is --**
 12 Q. Well --
 13 **A. Please let me finish. From D6 that he is only recently**
 14 **feeling able to actually disclose the fact that he was**
 15 **sexually abused as a young person.**
 16 Q. Well, you --
 17 **A. Therefore, there can be no limitation on that.**
 18 Q. Well, you are --
 19 **A. I'm sorry, I do not accept that I would accept**
 20 **limitation.**
 21 Q. Well, you are on your oath and the council's defences in
 22 a number of claims contained, paragraph 1, as we have
 23 heard, that the council is taking a limitation defence.
 24 So what you are saying is not true, is it?
 25 **A. Well, I would not -- I am not sighted on that, so**

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1 **say. What I can say is, as I said earlier, I'm very**
 2 **clear that the time from when something is alleged to**
 3 **have happened to the time of bringing the claim is not**
 4 **accepted by me as a reason for any delay. I cannot**
 5 **comment on what other legal processes there might be.**
 6 Q. Has your objective been to wear people down to stop them
 7 pursuing a claim?
 8 **A. Absolutely not. I'm sorry, I find that wholly**
 9 **offensive.**
 10 Q. I will move now to apologies. I'm not going to ask you
 11 about the corporate apology that Mr Sadd's covered with
 12 you. You have sought in your statement, signed
 13 yesterday and made available to us this morning, as you
 14 have heard about, to give an apology to L43. He was
 15 present at the inquiry and gave evidence. You could
 16 have given him a personal apology then, couldn't you?
 17 **A. I could have, yes, if that's what he had wanted. Of**
 18 **course.**
 19 Q. Same with L48. He was here at the inquiry. He doesn't
 20 even know that you intend to apologise to him because he
 21 is at work and doesn't know what's in your statement.
 22 That's not a very -- that's not much of an apology to
 23 these people, is it?
 24 **A. I've said very clearly today and through my evidence**
 25 **that, you know, I would offer my heartfelt and personal**

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1 **I cannot comment on that.**
 2 Q. In the case of L17, it took over six years to resolve
 3 her claim. L18, it took nearly seven years to resolve
 4 his claim. And L24, four years. All of that process
 5 has added to their suffering, hasn't it?
 6 **A. I'm sure it has, but, I'm sorry, I don't know what these**
 7 **particular cases are. I'm very sorry.**
 8 Q. All of that process costs the council money, doesn't it?
 9 **A. It would do, yes.**
 10 Q. Because it's spending money on lawyers to argue with and
 11 dispute claims that abuse claimants are bringing, isn't
 12 it?
 13 **A. So one of the things I have spoken about as president**
 14 **and also in relation to this is -- and I referred to it**
 15 **very briefly earlier, that the whole litigious nature of**
 16 **this I think is wholly inappropriate in the**
 17 **circumstances of these claims. The whole process around**
 18 **civil claims I think is in need of a huge overhaul.**
 19 **I have made some comment around that in my statement.**
 20 Q. You have. It's in your statement from yesterday, yes.
 21 **A. It's totally wrong.**
 22 Q. In your statement yesterday you made some comments about
 23 that. Are you now saying then that the council will no
 24 longer take any limitation defences in any other cases?
 25 **A. I cannot comment on that. That's not within my gift to**

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1 **apologies on behalf of the city council, too, for**
 2 **anybody that has been harmed in our care or by any**
 3 **subsequent processes. I am very happy to meet with**
 4 **anybody who would want to meet with me or my colleagues**
 5 **in the city council.**
 6 MR SIMBLET: That's all I ask, thank you.
 7 THE CHAIR: Thank you, Mr Simblet.
 8 MR SADD: Chair, do you or any of your colleagues have any
 9 questions?
 10 THE CHAIR: Yes. We will begin with Ms Sharpling.
 11 Questions by THE PANEL
 12 MS SHARPLING: Just a couple of questions, if I may,
 13 Ms Michalska.
 14 **A. Yes, of course.**
 15 MS SHARPLING: The first is, just going back to the public
 16 apology matters to which you referred earlier.
 17 **A. Yes.**
 18 MS SHARPLING: I'm just going to ask, if that kind of
 19 apology in public is dependent upon convictions in the
 20 public forum or in the public domain, might that well
 21 exclude the prospect of systemic abuse, where, for
 22 a variety of reasons, a criminal conviction is simply
 23 not on the cards?
 24 **A. I think -- please don't misunderstand what I have said.**
 25 **A conviction would be something that was very public and**

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1 **therefore the matter that we would be apologising for is**
 2 **already a matter of public record. By not wanting to**
 3 **apologise publicly for individual cases, it's not for us**
 4 **to make public somebody's personal trauma and abuse.**
 5 **I think we have been very clear and I think**
 6 **Councillor Mellen was very clear yesterday that the**
 7 **process of this inquiry is all to help us understand the**
 8 **nature of the abuse that's happened over a period of**
 9 **time, and that -- in short, we are absolutely sure that**
 10 **at the conclusion of the process, there will be things**
 11 **that the city council will very much want to publicly**
 12 **apologise for. So it doesn't have to be a conviction.**
 13 MS SHARPLING: You have also indicated a number of
 14 initiatives that were put in place I think as a result
 15 of the inquiry, and to cite two of them, the
 16 notification process and also record keeping, you have
 17 appointed somebody to deal with that.
 18 **A. The record keeping is an absolute direct response from**
 19 **the work we have been doing and the inquiry, that's**
 20 **absolutely right. The notifiable isn't new, other than**
 21 **the need to keep a central record is the new bit, not**
 22 **the process, just --**
 23 MS SHARPLING: I see.
 24 **A. -- being able to interrogate it.**
 25 MS SHARPLING: That's not my exact question, if you let me

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1 **other is their children's social workers offer support**
 2 **to adults. My view is, that part of the service should**
 3 **be delivered by adult social care.**
 4 THE CHAIR: I hadn't actually finished the question, which
 5 was, since you're in charge of both services, surely it
 6 was within your gift to set up such a team exactly as it
 7 should be configured, with a range of specialist
 8 services?
 9 **A. Well, we do have all of those specialist services. We**
 10 **provide the totality of the same -- with the exception**
 11 **of records -- as the county council does. We just don't**
 12 **have a dedicated team.**
 13 THE CHAIR: I don't quite understand why you don't have
 14 a dedicated team?
 15 **A. Because I didn't -- because I don't think that that was**
 16 **necessary to deliver the same quality of service.**
 17 THE CHAIR: I see. Thank you very much.
 18 MR SADD: Chair, would you be content to resume at 2.00 pm?
 19 THE CHAIR: Yes, indeed, Mr Sadd.
 20 (The witness withdrew)
 21 (1.18 pm)
 22 (The short adjournment)
 23 (2.00 pm)
 24 MR SADD: Good afternoon, chair and members of the panel.
 25 This afternoon, the first witness the inquiry is hearing

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1 finish.
 2 **A. Sorry.**
 3 MS SHARPLING: I'm asking, why has it taken the inquiry to
 4 trigger these new initiatives?
 5 **A. It's taken the inquiry because I wasn't aware that, for**
 6 **example, when somebody wanted to see their information**
 7 **that that was just sent to them. I wasn't aware that we**
 8 **didn't already personally sit down and explain that to**
 9 **somebody and, similarly, I wasn't aware until we were**
 10 **asked a question about aggregating information out of**
 11 **notifiables, I wasn't aware that we weren't able to do**
 12 **that. So the inquiry has raised with me issues that, as**
 13 **a director, I did not know about.**
 14 MS SHARPLING: Thank you.
 15 THE CHAIR: Just one question from me, Ms Michalska:
 16 regarding an aspect of your explanation about the city
 17 not having a dedicated historical abuse team.
 18 **A. Yes.**
 19 THE CHAIR: You seemed to stress strongly that you thought
 20 it was for -- it should be -- that such a team should be
 21 staffed by adult specialists.
 22 **A. Not all the team, no, but -- so in summary, in my**
 23 **understanding of the historic abuse team in the**
 24 **county council, it does a range of things, one of which**
 25 **is searches records which I think is a police task. The**

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1 from is Colin Pettigrew, a corporate county council
 2 witness. His statements are at NSC001235 and NSC001474.
 3 MR COLIN PETTIGREW
 4 Examination by MR SADD
 5 MR SADD: Mr Pettigrew, good afternoon.
 6 **A. Good afternoon.**
 7 Q. You have provided two statements to the inquiry, as you
 8 heard me a moment ago saying. The first is
 9 dated July 2018. It runs to 165 pages and effectively
 10 carries out a review of both past and present policies
 11 and procedures. The second statement, dated
 12 1 August 2018, is 34 pages. Both have come with
 13 extensive exhibits.
 14 At the time that you signed these statements,
 15 I understand of course that the first statement will
 16 have been prepared on the basis of all sorts of
 17 information being provided to you, but you were
 18 satisfied that where you could speak to the truth of
 19 things, it was true as far as you were concerned?
 20 **A. That's correct.**
 21 Q. Are there any simple corrections that you need to make?
 22 **A. Just a very small correction, and I'm not sure where to**
 23 **take you in the document because we haven't had the**
 24 **preparation. I started working for Nottinghamshire**
 25 **County Council on 28 September 2015. However, I had**

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<p>1 a two-week period of induction where I shadowed the 2 interim director of Children's Services at that point, 3 and actually my first date of being the statutory 4 director would have been 11 October 2015. 5 Q. Thank you for that. The panel have a copy of your 6 statements, and the whole statements will be uploaded 7 onto the website. As you will have heard, by now, me 8 say frequently, we are not going to go through the 9 statements line by line or indeed page by page, but I am 10 going to take you to particular topics which have been 11 identified to you, and I may ask you to comment on 12 documents which we will be bringing up on screen. 13 You are currently the corporate director of 14 children, families and school services with 15 Nottinghamshire County Council? 16 A. Yes, that's correct. 17 Q. We are going to go first to the topic of 18 the notification that you are given of contemporaneous 19 allegations of sexual abuse. Are you informed of all 20 allegations of sexual abuse made in relation to 21 residential or foster care within the county? 22 A. Yes, I am. 23 Q. Page 44 of your first statement, if we can go to that. 24 A. Yes, I'm there now. 25 Q. In fact, we need to go back a page, because we are going</p> <p style="text-align: center;">Page 129</p>	<p>1 to be looking at what is set out at paragraph 3c.iii.26. 2 You say there on page 43: 3 "As director of Children's Services, I report to the 4 lead member for Children's Services." 5 You say who the two vice chairs are. You say: 6 "In relation to allegations of sexual abuse, 7 I report to the lead members when a current or former 8 member of staff or foster carer is charged, appears in 9 court or is sentenced ... " 10 Just reading on: 11 "The role of the elected members on receiving such 12 reports is to seek assurance that other senior officers 13 and myself are dealing appropriately with the matter and 14 to provide appropriate challenge." 15 I should have read, just before that, that you say 16 what you will report to the lead members are "any other 17 matters that in my professional judgment need to be 18 escalated". What criteria, please, Mr Pettigrew, do you 19 apply in your professional judgment as to what should be 20 escalated? 21 A. In response to this inquiry, which has shone a very 22 bright torch on the work of the county council, and 23 picking up on a question that Ms Sharpling asked 24 earlier, we have reflected on why we didn't have 25 a previously written protocol that gave a parameter for</p> <p style="text-align: center;">Page 130</p>
<p>1 me -- myself and Councillor Owen, and in early summer 2 felt that this should be, yes, but that was a bit of 3 a vacuum, but it was left entirely to my professional 4 judgment. 5 Q. Mr Pettigrew, you have established criteria? 6 A. Yes, we established criteria and protocol and we 7 submitted that as evidence. 8 Q. In that criteria, does that include informing about 9 disciplinary cases which relate to child sexual abuse of 10 children in care? 11 A. Yes, it would. 12 Q. Can we go, please, to tab 6 of the bundle, and this is 13 document NSC001478. We are going to look at page 67 and 14 then it includes pages 71 to 139. This was a case, 15 Mr Pettigrew, in which a child was sexually abused by 16 another child in residential care and an independent 17 investigation found that the staff failed in their duty 18 of care to the victim child. It also recommended that 19 the department consider offering an apology and consider 20 appropriate redress. 21 If we go to page 113, please -- 22 A. Of my statement? 23 Q. No, of the document. 24 A. Right, sorry. 25 Q. We can see that that is the consequence of</p> <p style="text-align: center;">Page 131</p>	<p>1 the investigation, and under "Recommendations", the 2 suggestion is, at 9.1: 3 "That A588 receives a letter acknowledging the 4 failings that have been identified in this report. 5 "That the department considers offering him an 6 apology for failing in their duty of care towards him. 7 "That consideration is given to appropriate 8 redress ... in the light of the abuse he suffered whilst 9 in the care of Nottinghamshire County Council." 10 That was on 7 October 2015. Do you recall when it 11 is that you first found out about this case? 12 A. Yes, it wasn't at this occasion, it was subsequently. 13 I can't remember the exact date, but I could provide 14 that in writing, if that would be helpful. Yes, it was 15 with regards to representation, yep, from his advocate, 16 yep, his independent advocate, when he was -- I shan't 17 say -- he was living in another part of England. 18 Q. I think it is right, if we go to page 133 of this part 19 of the bundle, if that could be up on screen, this is 20 a letter dated 11 May 2017. So from 7 October 2015 to 21 11 May 2017. This is you, if we go to page 135, we see 22 that you have signed a letter. 23 A. I did. 24 Q. You were addressing it to A588 and you say: 25 "I'd like to thank you for your patience and</p> <p style="text-align: center;">Page 132</p>

<p>1 apologise for the time it has taken to write to you with 2 a decision about your complaint." 3 The suggestion that had been made in 2015 was that 4 the county apologised to A588. Can you remember why it 5 took over 18 months from the date of the report to this 6 letter of apology? 7 A. No, I can't, I'm afraid. Sorry. 8 Q. In fairness to you, some of the reasons are set out in 9 that second paragraph of the letter. This was a case 10 relating to harmful sexual behaviour -- 11 A. It was. 12 Q. -- of a child in the care of the county. At the time, 13 that is, 2015, that the investigation was completed, 14 that the council accepted responsibility and that they 15 were going to advise on obtaining redress, were you 16 aware of harmful sexual behaviour as a significant issue 17 relating to children in the care of the county? 18 A. No. I was aware of this case, and I can see now, and 19 thank you for bringing it to my attention, that when 20 Amanda Collinson had met A588, he raised further 21 concerns with regards to how his complaint had been 22 handled and how his case had been handled and Amanda 23 gave a commitment to go away, and I think there is 24 a full letter from Amanda that outlines a response to 25 those things.</p> <p style="text-align: center;">Page 133</p>	<p>1 Q. You say, please, if we go to page 134 at part 6 of 2 the bundle, at the top there, again, writing to this 3 individual: 4 "I can assure you that in response to the 5 investigator's second recommendation we have given 6 careful consideration to the options available for an 7 appropriate remedy for the harm you have suffered. We 8 would be happy to support you to make a claim with the 9 Criminal Injuries Compensation Board ... 10 "In addition, your request for compensation from the 11 council for the harm and assault you have suffered will 12 be met via Zurich, our public liability insurers. We 13 have therefore logged a claim on your behalf and they 14 will be in contact with you to discuss the process for 15 settlement of your claim." 16 A. That's correct. 17 Q. More recently, at page 139, this is as recently as 18 2 August 2018, you're writing there to Amanda Collinson? 19 A. That's correct. 20 Q. You have revisited this person's case file and we can 21 see that "the progress of his claim for compensation 22 against us: this relationship has gone cold". Do you 23 have that, four lines up from the bottom of the text? 24 A. I do. 25 Q. "Could I ask that you make contact with [this</p> <p style="text-align: center;">Page 134</p>
<p>1 individual] via the Social Services Department. 2 Encouraging him to re-establish contact with that 3 solicitor or another firm to progress his claim." 4 Just a question to you. If we go back one or two 5 pages to 136, September 2017, we see the solicitors 6 putting in the claim. If you go to 137, we can see the 7 insurers, Zurich I think it is, saying, "We will get 8 back in touch with you once those investigations have 9 been considered and we will carry out our own 10 investigations into legal liability". Somewhere along 11 the line, Mr Pettigrew, the original decision that this 12 individual should get compensation and that you were 13 encouraging him to make that application seems to have 14 been lost, so that he was going through the process of 15 actually having to make a claim and that the issue was 16 still being investigated. Do you know how that 17 happened? 18 A. I don't know whether that reflects that that has been 19 lost. My understanding, and I may be wrong, again, 20 because it is not my area, is that the young person 21 would still have to go through the process. He is also 22 a minor, and that, therefore, would need to be 23 considered, I understand, through the court process. If 24 I have got that wrong, I apologise, but that is my 25 understanding.</p> <p style="text-align: center;">Page 135</p>	<p>1 Q. Your understanding is based on the fact that any damages 2 that would be given to him have to be approved by the 3 court. Is that what you mean? 4 A. That's my understanding, yes. 5 Q. Do you have freedom, Mr Pettigrew, to admit liability on 6 the part of the council where you think it appropriate? 7 A. Where it's clear that we have failed a child or young 8 person, I think I do. I think that the inquiry has 9 heard from different tiers of the county council, from 10 Rachel Morton to Steve Edwards to Councillor 11 Philip Owen. It's our view that, where we have been 12 found wanting, and in this case we absolutely were, we 13 failed this young man, then we should move to settle 14 quickly. 15 Q. Would that be something that you have to get the 16 approval of your lawyers or insurers of, in writing -- 17 so in writing that letter where you're saying, "You must 18 make a claim, go through this process", would that have 19 had to be approved by insurers and solicitors? 20 A. Within many local authorities, Mr Sadd, I think there is 21 some confusion with regards to the relationship between 22 legal and someone like myself, a corporate director. 23 I will always ask legal for advice, but that's what it 24 is, it's advice. It's for me to make a decision then as 25 to whether I follow that advice, yep, and how I might</p> <p style="text-align: center;">Page 136</p>

<p>1 instruct those -- that legal department. Insurance 2 companies I think are a different kettle of fish, and 3 I think we do, with the greatest of respect, need to 4 unpick some of this within the reparation investigation. 5 There's certainly confusion as to tail and dog. 6 Q. One of the complainant witnesses, if we can move on, who 7 gave evidence on Day 3, F37, gave evidence about being 8 sexually and physically abused by F235, her foster 9 father, in the 1970s. There were some records in 10 relation to this, and she spoke about how she came 11 forward to the council in 2015. The person case notes 12 from October 2015 note the LADO's decision that there 13 won't be a strategy meeting, given that two of 14 the alleged perpetrators had died, and F37 was very 15 critical of this decision. 16 We know from other documents that there were 17 attempts to contact F37 to explain the position to her, 18 but what I really want to ask you is a broader question, 19 because we heard from Rachel Morton on Tuesday about 20 what she considered to be an inconsistent approach being 21 adopted by the county council in relation to the holding 22 of strategy meetings and the reaching of an outcome in 23 relation to allegations against perpetrators who were 24 deceased. She thought that this should happen because 25 it would be of benefit for the complainants.</p> <p style="text-align: center;">Page 137</p>	<p>1 Mr Pettigrew, do the county council now hold 2 strategy meetings and aim to reach an outcome, that is, 3 substantiated, unsubstantiated, et cetera, in relation 4 to deceased perpetrators? 5 A. No, we don't. May I offer an explanation to that? 6 Q. I am going to ask you why you don't. 7 A. Okay, thank you. The genesis of the LADO strategy 8 meeting, local authority designated officer, has its 9 genesis within HR, human resource, procedures, and it's 10 with a view to coming to a conclusion as to whether an 11 allegation against someone in a position of trust has or 12 hasn't been involved in the abuse of a child. 13 Part of the rationale behind those regulations or 14 those guidance that was originally published within 15 Working Together was -- so, for instance, where there 16 was an occasion where a teacher had an allegation 17 against him or her, and found themselves not at work, 18 there was a process that would inform whether he or she 19 should be allowed to return to work or should be 20 dismissed that was outside of a criminal process. 21 I think what we have seen is that process begin to 22 move into how we engage with victims and survivors or 23 people who are alleging stuff. That has led to my view. 24 Examples -- I think you've seen an example from the 25 city council of really what I think are not good</p> <p style="text-align: center;">Page 138</p>
<p>1 examples of correspondence that's sensitive to victims' 2 and survivors' needs. 3 Q. Can we go, please, to your first statement and to 4 page 49 and to section 4. This is you addressing the 5 way in which senior management with responsibility for 6 children in care were held to account in practice. Do 7 you have it now? It is page 49. It is under 4(a), the 8 first main paragraph: 9 "Until the early 1970s, members held full direct 10 responsibility for children coming into care and 11 children in care ... council employees would have 12 reported directly to the Children's Committee ..." 13 You conclude, having set that out: 14 "Therefore, through the 1970s and 1980s ..." 15 Do you have that, three lines up from the bottom of 16 that paragraph? 17 A. I do, yes. 18 Q. "... as day-to-day decision making was increasingly 19 delegated to officers, the role of elected members 20 gradually became more of holding officers to account." 21 Having heard the evidence over the last three and 22 a half weeks, and I think you have sat in on every day 23 of the inquiry's hearings; is that right? 24 A. I have been here every single day, yes. I haven't 25 managed to sit in every session. There's two sessions</p> <p style="text-align: center;">Page 139</p>	<p>1 out of the 28 or so that have happened that I have not 2 been here. 3 Q. Do you accept that, having heard the evidence of core 4 participants here, in practice, senior management were 5 not held to account by councillors throughout the '70s 6 and 1980s? 7 A. I agree with that. I agree. 8 Q. We are going to look at practice in the early 1990s, in 9 the light of a very recent statement that has been 10 provided to core participants. That statement is of 11 Diane Kingaby and her report written in 1991. That's to 12 be found -- 13 A. Sorry, Mr Sadd? Are you going to take me to it, sorry? 14 Q. Yes, I am going to take you to tab 15 and tab 19. 15 I just ask you this: have you had a chance to read -- 16 A. I have. I received these early evening of yesterday, 17 yes, and I apologise if my responses are either limited 18 or restricted by that. However, if we can help further, 19 we will add to any oral evidence I give in writing, as 20 invited by yourself. 21 Q. At tab 15, we have a document written by her in 1991 22 where she sets out her experience of working in social 23 work in the county. Then at tab 19, we have her 24 statement to the inquiry about how that document came to 25 be generated and her memory.</p> <p style="text-align: center;">Page 140</p>

<p>1 We go first, please, to tab 19, paragraph 3, please, 2 the first page of her statement. She says that during 3 councillor rota visits, about which the inquiry has 4 heard a good deal of evidence, managers were told not to 5 talk about contentious issues, and then we go to 6 paragraph 4, over the page: 7 "Managers acted to avoid the Social Services 8 Committee, knowing about the extent of abuse in 9 children's homes, as they believed that the response 10 would be negative." 11 The next paragraph down, the final sentence there: 12 "We were all instructed ..." 13 Do you have that? 14 A. Sorry, which page am I on? 15 Q. You're in tab 19. 16 A. I am. 17 Q. You're looking at the second page of the statement. 18 A. I only have one paragraph on that second page, if I'm on 19 the same document. 20 Q. If we have it up, then, on screen, please, INQ002957. 21 A. That's the one I have. I only have one paragraph on my 22 second page. 23 Q. Yes. It is now on your screen. I'm sorry that you 24 haven't got the proper page, but if you look at what's 25 on your screen, what I'm taking you to is the second</p> <p style="text-align: center;">Page 141</p>	<p>1 paragraph on that page that should be there, but it 2 isn't. In the statement, she writes, and it's been 3 highlighted: 4 "We were all instructed to tell social workers that 5 they should try anything to avoid their child coming 6 into residential care as they were more likely to be 7 sexually abused than not." 8 I should add that Ms Kingaby was a senior 9 professional officer at the time. Would you want to 10 comment on what I have read out? Is there anything that 11 you would want to reflect on? 12 A. You're asking me to immediately reflect on something 13 I have never seen before. 14 Q. You haven't seen this? Forgive me. I thought -- 15 A. No, I don't have page 2 in the bundle that you have 16 provided me with. 17 Q. Perhaps you may be able to answer this question, though: 18 in the course of meeting and investigating claims made 19 in Daybreak and Equinox, can the panel assume that the 20 council met with and discussed past practice with 21 retired officers to understand better how things had 22 worked in the past? 23 A. Yes, we have. 24 Q. Did you have those sorts of debriefings? 25 A. We have had those kinds of conversations during</p> <p style="text-align: center;">Page 142</p>
<p>1 preparation for the Independent Inquiry Into Child 2 Sexual Abuse as well. It's unfortunate that this 3 witness has come forward so late because that would have 4 been helpful. 5 Q. I understand that. 6 A. Sorry, I was going to go on to say, I'm not trying to 7 dodge your question -- 8 Q. No, I understand that. 9 A. Ms Kingaby I understand to be someone who has worked for 10 the department for -- she refers to leaving, but I think 11 returned to work for the department for a long time. 12 She's a credible witness, would be my view. If that's 13 what she was writing contemporaneously, I would have no 14 reason and no evidence to suggest that wasn't the case. 15 Q. I don't need to ask my next question then. Can we then 16 go, please, to response to allegations against foster 17 carers. Making you go all the way back now to your 18 statement, please, page 41, and I want us to look at 19 paragraph 3c.iii.17, the paragraph at the end of that 20 page starting, "Where a decision is made to move or not 21 move the children". Do you have that? 22 A. I do. 23 Q. We can see in the second sentence: 24 "Current placements may remain if discussed and 25 agreed with the fostering services manager, the</p> <p style="text-align: center;">Page 143</p>	<p>1 fostering team manager and the service manager for the 2 child. There would be no further children placed with 3 the carer until the matter is resolved." 4 In what circumstances would it be appropriate, 5 Mr Pettigrew, for the child to be left in the placement 6 or for a child, I should say, to be left in the 7 placement? 8 A. I think the -- under the exceptional circumstances that 9 this would be the case, there would be senior management 10 oversight, is what that paragraph reflects, that it 11 wouldn't be made at a junior level, it would have to 12 have management sign-off. 13 I would suspect -- if there was a situation, for 14 instance, where a child had been abused by an older 15 birth child of the foster carers, maybe an adult, and 16 that that adult had been removed from the home either 17 through being remanded in custody or being somewhere 18 that we knew where he or she was, and we had the view 19 that the foster carers had an ongoing strong 20 relationship and commitment to the child that they 21 fostered -- some of these foster placements last a long 22 time -- and would be able to meet the emotional needs of 23 that child and young person and were prepared to do so, 24 I think that would be the kind of exceptional 25 circumstances. But you're asking me a bit of "How long</p> <p style="text-align: center;">Page 144</p>

<p>1 is a piece of string?".</p> <p>2 What I would want to emphasise, it would be the</p> <p>3 exception rather than the rule, and there would be some</p> <p>4 safeguards put around that with regards to senior</p> <p>5 management having oversight.</p> <p>6 Q. I'm not going to ask you to go to this. I'm going to</p> <p>7 read it out to you, to help you. This is your second</p> <p>8 statement, page 28. It is paragraph 4h.14. There you</p> <p>9 are dealing with the issue of visits by placing social</p> <p>10 workers. You say this:</p> <p>11 "The social worker must see and speak to the child</p> <p>12 alone, where able to do so. It is recognised that older</p> <p>13 children do not always agree to speak to their social</p> <p>14 worker. However, visits and reasons that a child has</p> <p>15 not been seen alone should always be recorded. The</p> <p>16 social worker should always give the child the</p> <p>17 opportunity to meet outside of the placement. This</p> <p>18 gives additional opportunities for the child to raise</p> <p>19 any issues with the social worker about the quality of</p> <p>20 the placement, who would then liaise with the</p> <p>21 supervising social worker and/or bring the concerns to</p> <p>22 the attention of the relevant manager, if required."</p> <p>23 The first sentence of that paragraph, I will read it</p> <p>24 again:</p> <p>25 "The social worker must see and speak to the child,</p> <p style="text-align: center;">Page 145</p>	<p>1 where able to do so."</p> <p>2 That appears to be a qualification. Isn't it</p> <p>3 mandatory for the social worker to see the child alone?</p> <p>4 A. We measure that, yes. It's good practice and it is</p> <p>5 a measure that our systems allow us to identify. Yes,</p> <p>6 we do case file audits on that and we inspect and</p> <p>7 critically assess ourselves against that.</p> <p>8 Q. So where does the qualification arise in this paragraph,</p> <p>9 "The social worker must see and speak to the child</p> <p>10 alone, where able to do so"? That suggests there may be</p> <p>11 circumstances where the social worker won't be able to</p> <p>12 do so?</p> <p>13 A. I think there will be circumstances where, on occasion,</p> <p>14 a social worker might not be able to do so. And on</p> <p>15 occasion, as you pointed out quite rightly, Mr Sadd,</p> <p>16 where the child or the young person expresses a view</p> <p>17 that they don't wish to do that. However, if it were</p> <p>18 the case on every visit, that would give us significant</p> <p>19 cause for concern.</p> <p>20 Q. We can carry on back to your first statement, which you</p> <p>21 have open. I want us to look at paragraph 3c.iv.12. It</p> <p>22 is page 48.</p> <p>23 A. I'm on that page.</p> <p>24 Q. Where you say:</p> <p>25 "in order to ensure independence, it is sometimes</p> <p style="text-align: center;">Page 146</p>
<p>1 necessary to commission external investigators to look</p> <p>2 into matters of concern."</p> <p>3 You say this was done -- you say later on at</p> <p>4 3c.iv.13, just below, this was done in relation to</p> <p>5 Patrick Gallagher's case. Mr Pettigrew, in your view,</p> <p>6 can independence ever be assured with an internal</p> <p>7 investigator? You say that in certain circumstances you</p> <p>8 will use an external investigator. Shouldn't the</p> <p>9 default position be always to use an external</p> <p>10 investigator?</p> <p>11 A. There would never be an internal investigator with</p> <p>12 regards to a Serious Case Review, which</p> <p>13 Patrick Gallagher was. To help the inquiry, if I could</p> <p>14 also point out, the decision, who will be the</p> <p>15 independent author of a Serious Case Review, is not one</p> <p>16 that's made within the county council, it's one that's</p> <p>17 made by the independent chair of the LSCB. I think at</p> <p>18 c.iv.11, it begins talking about Serious Case Reviews.</p> <p>19 Two paragraphs further down, it's talking about an</p> <p>20 independent management review. So 11 would be</p> <p>21 a circumstance where Mr Chris Few would have identified</p> <p>22 an independent author, and 3c.iv.13, when it was</p> <p>23 a management review of NF77, that would have been</p> <p>24 a decision of Steve Edwards.</p> <p>25 Q. Page 90 of your statement, please.</p> <p style="text-align: center;">Page 147</p>	<p>1 A. Sorry, Mr Sadd. May I ...?</p> <p>2 Q. Go on.</p> <p>3 A. We have mentioned A588, and on that occasion, the normal</p> <p>4 process would have been he made a complaint. That</p> <p>5 complaint should have been dealt with at stage 1 in</p> <p>6 normal process. Stage 1 would have been an internal</p> <p>7 investigation at as low level as possible, so a local</p> <p>8 manager. It was felt by Steve Edwards on that occasion</p> <p>9 that the allegations and the complaints were so serious</p> <p>10 it should skip stage 1, go straight into stage 2 of</p> <p>11 the complaint, and independent complaints investigators</p> <p>12 appointed.</p> <p>13 Q. Page 90, please, paragraph 50.6. This is in relation to</p> <p>14 NO-F77. Following the allegations of abuse against him</p> <p>15 reference is made to giving "consideration to all</p> <p>16 children who had been placed with the foster carers".</p> <p>17 In the following paragraph, it's said that files were</p> <p>18 reviewed for all the children who had made allegations.</p> <p>19 Does this suggest, Mr Pettigrew, that the other children</p> <p>20 who had been in the placement did not have their files</p> <p>21 reviewed in this process?</p> <p>22 A. No, Mr Sadd. You heard from Yvonne Dales that in both</p> <p>23 the Gallagher case and the F77 case, all children who</p> <p>24 had been placed there were given the opportunity to be</p> <p>25 seen and part of that being seen would have been</p> <p style="text-align: center;">Page 148</p>

<p>1 a review of files, I am sure.</p> <p>2 Q. For instance, in 2000, when this case first came to</p> <p>3 light, albeit admittedly with allegations made by</p> <p>4 another child, and we know what the conclusion of that</p> <p>5 2000 investigation was, we know that no other files were</p> <p>6 investigated, is it your view that they should have</p> <p>7 been, given the allegation being made?</p> <p>8 A. In 2000, yes.</p> <p>9 Q. So, so just over the page, please, this discusses the</p> <p>10 approach which was adopted as an alternative to the</p> <p>11 rotation of supervising social workers to regularly</p> <p>12 consider the record and scrutiny of the challenge being</p> <p>13 provided to social workers, and you may remember the</p> <p>14 evidence that was given on that and the discussion that</p> <p>15 I had with Jayne Austin in relation to that.</p> <p>16 This management overview of supervising social</p> <p>17 workers, was made, as I understand it, operational</p> <p>18 in November 2012. Jayne Austin left in 2016 --</p> <p>19 A. She did.</p> <p>20 Q. -- and says she can't recall having seen the outcome of</p> <p>21 any reports prepared in the wake of this decision. How</p> <p>22 has this operated in practice?</p> <p>23 A. I understand -- again, this predates me -- the</p> <p>24 conclusion was reached, having done a feasibility study,</p> <p>25 that we wouldn't move towards rotating social workers.</p> <p style="text-align: center;">Page 149</p>	<p>1 I think in my 35 years of social worker experience,</p> <p>2 there has always been an ongoing debate around rotation</p> <p>3 or not rotation. There is a view about the strength of</p> <p>4 building relationships and knowledge and organisational</p> <p>5 memory. We were inspected and fostering was part of</p> <p>6 that inspection in 2015, three years after this, and</p> <p>7 I understand the fostering service was found to be good</p> <p>8 by Ofsted externally. That inspection took four weeks</p> <p>9 with its inspectors. It was thorough and comprehensive.</p> <p>10 The seven district fostering teams that Jayne Austin</p> <p>11 described, we identified, and one of those teams</p> <p>12 I understand, Mansfield, there were particular issues,</p> <p>13 and those issues were addressed through a management</p> <p>14 action plan and including management oversight. It was</p> <p>15 felt, I understand, that to change the entire structure</p> <p>16 on the basis of some failings that we found -- that we</p> <p>17 checked all fostering teams, but we found in particular</p> <p>18 one was not the way forward.</p> <p>19 Q. Indeed, Mr Pettigrew, that's set out in her feasibility</p> <p>20 study and she sets out the impracticalities of</p> <p>21 rotational supervisory social workers, and the</p> <p>22 alternative is more stringent management oversight.</p> <p>23 Do you know if there's in existence any systematic</p> <p>24 reviews carried out of that management oversight and how</p> <p>25 it's worked out in practice?</p> <p style="text-align: center;">Page 150</p>
<p>1 A. So we have added into this fostering service two</p> <p>2 additional independent reviewing officers who are</p> <p>3 responsible for the reviewing, the annual reviews, of</p> <p>4 our foster carers. Previously to that, it would have</p> <p>5 been done by the team managers within the service. We</p> <p>6 think that gives some additional independence. I'm sure</p> <p>7 we will revisit the whole notion of independence within</p> <p>8 the social work setting.</p> <p>9 Q. It may be I'm not putting my questions very well. I'm</p> <p>10 not concerned so much with reviewing the foster carers</p> <p>11 themselves. I am concerned with the review and</p> <p>12 management oversight of the supervisory social workers</p> <p>13 who are attached to the foster carers. It is the need,</p> <p>14 which was recognised in the wake of the Mansfield</p> <p>15 issues, for there to be some scrutiny of that continuing</p> <p>16 relationship.</p> <p>17 What we have been discussing is: no, we shouldn't</p> <p>18 have rotational supervisory social workers. Who is</p> <p>19 now -- or are you confident that what is now in place</p> <p>20 means that the need to supervise how placements are</p> <p>21 going, so far as the supervising social worker is</p> <p>22 concerned, is being properly managed?</p> <p>23 A. Supervising social workers' line managers scrutinise the</p> <p>24 relationship and the approach of those supervising</p> <p>25 social workers.</p> <p style="text-align: center;">Page 151</p>	<p>1 Q. And they do so on a regular basis?</p> <p>2 A. I understand they're supervised every month.</p> <p>3 Q. That's part of a written report?</p> <p>4 A. They would make a record of that supervision, yes, and,</p> <p>5 in turn, the line manager of the team managers would</p> <p>6 have supervision with those line managers and part of</p> <p>7 that focus would be their supervision.</p> <p>8 Q. Are you aware of any supervising social workers who have</p> <p>9 been reassigned as a result of that review?</p> <p>10 A. No, I'm not.</p> <p>11 Q. Do you get provided with an annual report on the review</p> <p>12 of supervising social workers?</p> <p>13 A. We're provided with the fostering service annual report,</p> <p>14 and that comes not only to my senior leadership team but</p> <p>15 also to the Children and Young People's Committee.</p> <p>16 Q. That includes an item on the supervision of social</p> <p>17 workers?</p> <p>18 A. I have to confirm that to you, yes.</p> <p>19 Q. Can we look, please, at the approach taken to civil</p> <p>20 claims and apologies, please, in general. At</p> <p>21 paragraph 1.4 of your statement, page 2, you note:</p> <p>22 "The county has received approximately 200 civil</p> <p>23 claims relating to sexual abuse of children whilst in</p> <p>24 our care."</p> <p>25 One issue raised, Mr Pettigrew, by numerous</p> <p style="text-align: center;">Page 152</p>

1 complainants is about claims being settled for what they
 2 perceive to be low offers. What considerations does the
 3 county take into account when coming up with a valuation
 4 of settlement offers?
 5 **A. My understanding is that that is negotiated between the**
 6 **county's solicitors and the claimant's solicitors.**
 7 Q. Do you have any input in what you consider to be just
 8 reparation for individuals who have been abused in care?
 9 **A. With regards to in terms of value? No, I don't. I'm**
 10 **advised by people that manage these areas, the risk and**
 11 **insurance, there's a whole range of elements considered.**
 12 **So, for instance, very recently, I have looked at the**
 13 **notional value of what we think a future claim might be**
 14 **worth. Indeed, it's with regards to A588. And I can**
 15 **see within that there's an amount for emotional harm,**
 16 **physical harm, potential future loss, but also for**
 17 **counselling within that. Now, I haven't seen that**
 18 **against another claim before, but I'm assured by my**
 19 **colleagues that that's as within previous settlements.**
 20 **I have to say that I'm as frustrated with this**
 21 **process as anyone else. Within the context of this**
 22 **inquiry, I have been exploring with our risk and**
 23 **insurance colleagues this whole notion of loss**
 24 **against -- vis-a-vis harm. I'm advised that a young**
 25 **person who would come into a Nottinghamshire children's**

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1 "Since costs are often borne by insurance companies,
 2 local authorities cannot unilaterally decide how a case
 3 is to be conducted, eg, settlement, limitation arguments
 4 and matters of proof."
 5 Indeed, you have already touched on that with me
 6 this afternoon. What role, as you understand it, do
 7 insurers play in decision making regarding civil claims?
 8 **A. I think they're engaged with our risk and insurance**
 9 **department. They have conferences with -- as**
 10 **I understand it, and I have been to one of those**
 11 **conferences several years ago to observe them, where**
 12 **they considered those claims.**
 13 **I do need to clarify a point, not from my statement,**
 14 **but where we are with regards to civil claims. What is**
 15 **within my sovereignty and the sovereignty of the local**
 16 **authority is where those claims, yep, are not insured,**
 17 **yep, and we are the party, so we are not working with**
 18 **a third party through insurance. In those cases, we**
 19 **will not be using limitation in future as a defence.**
 20 **That's within our gift and that's what we will be doing.**
 21 **So we will no longer be using limitations. We will also**
 22 **continue to work with that third party, our insurers, to**
 23 **encourage them to do the same. I met with our insurers**
 24 **in January of this year and had that conversation. They**
 25 **were still of the view collectively that limitation was**

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1 **home and experience -- be anally raped in the 1980s or**
 2 **'90s by a residential worker compared to a young person**
 3 **that might go to an independent Benedictine monks'**
 4 **fee-paying school and experience the same horrific**
 5 **abuse, that the level of loss that would be negotiated**
 6 **would be higher because of that individual's potential**
 7 **loss of income, career, et cetera. That's just**
 8 **scandalous, in my view, absolutely scandalous.**
 9 Q. One matter raised by Rod Jones in his evidence to the
 10 inquiry was about the role of insurers in responding to
 11 civil claims -- something we have already canvassed. At
 12 paragraph 1.6, still on that page of your statement, you
 13 say:
 14 "For some periods, the county is insured. Insurers
 15 clearly have a financial interest in the claims and, if
 16 the claim spans an insured period, they will ultimately
 17 make decisions over whether or not to settle and the
 18 level of any offers. It should also be noted that for
 19 some periods the county does not have the benefit of
 20 insurance and claims falling into these periods are
 21 managed internally. However, claims tend to span
 22 a number of years. This usually means that there are
 23 a number of insurers and often self-insured periods
 24 involved..."
 25 At 7c.5, you say:

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1 **available within law and therefore it was something that**
 2 **they may fall back on or use.**
 3 **Chair, I really think that this has got to be**
 4 **something that the inquiry considers with regards to**
 5 **insurance. This hearing, and we have heard today that**
 6 **these insurance claims are treated as other insurance**
 7 **claims. Tripping over a step in a council park is not**
 8 **the same as being in the care of the local authority and**
 9 **being grossly let down and sexually abused by an**
 10 **employee of the local authority. It is simply not the**
 11 **same, and limitation cannot apply in those**
 12 **circumstances.**
 13 **If it was in my gift to instruct insurance**
 14 **companies, I would, and I would have done it a long time**
 15 **ago.**
 16 Q. Again with your first statement, paragraph 3c.iii.20, at
 17 page 42, this is in the context of discussing current
 18 practice. I will give you the opportunity to get there.
 19 Do you have it?
 20 **A. 42, I'm there.**
 21 Q. You say:
 22 "On completion of the managing allegations process,
 23 a decision is reached on the outcome, eg whether the
 24 allegation is deemed to be substantiated.
 25 Responsibility for any disciplinary action is for the

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1 employer in the case of a member of staff."
 2 Is that decision made, as far as you know, by the
 3 chair of the strategy meeting?
 4 **A. The chair of the strategy meeting will make**
 5 **a recommendation to the employer, so they will reach**
 6 **a conclusion as to whether they believe it to be**
 7 **substantiated.**
 8 **This might be an employer or it might be a voluntary**
 9 **organisation.**
 10 Q. But given the conclusion that they reach in
 11 circumstances, for instance, where they say it's
 12 substantiated, does that decision reached at the
 13 strategy meeting inform the approach then taken to
 14 a claim?
 15 **A. I don't know. I would hope so, but I don't know.**
 16 Q. Do you think it's something that you would be able to
 17 establish generally?
 18 **A. Yes, I can take that away and look at that, yes.**
 19 Q. Paragraph 1.5, page 2. This is where you set out in
 20 some detail the apology made by the leader of
 21 the council, Kay Cutts, in January 2018. Do you have
 22 that?
 23 **A. Yes, I am there, thank you.**
 24 Q. Part of the apology included a pledge that victims and
 25 survivors will not feel that their abuse has happened

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1 **might be.**
 2 Q. Your understanding being that only when there is some
 3 definitive prognosis, can the claim be valued. Is that
 4 your understanding?
 5 **A. Sorry?**
 6 Q. Only when there's a definitive prognosis in relation to
 7 an individual who has been impacted psychiatrically is
 8 it possible to settle a claim?
 9 **A. I think it's difficult -- I think what we are coming**
 10 **back to is trying to make a risk and insurance claim**
 11 **arrangement fit these circumstances, and I believe it**
 12 **doesn't fit. There must be ways of finding some kind of**
 13 **partial settlement that actually allows victims and**
 14 **survivors to get some -- to use that. So the situation**
 15 **of us providing monies for therapy or counselling within**
 16 **a financial settlement that takes years means there's**
 17 **a gap and a vacuum, and I think we need to look towards**
 18 **our strategic partners and ourselves as to how we do**
 19 **that. But I don't think the current system is working.**
 20 **I think -- but it's the system that we are working in at**
 21 **the moment.**
 22 Q. Page 3, please, of your statement, paragraph 1.9. Here
 23 you set out some of the reasons for incomplete record
 24 keeping. I will just give you the opportunity to see
 25 that. Do you have it?

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1 without steps being taken to address the failings of
 2 the past. Do you think that the current approach to
 3 civil claims fulfils part of that pledge?
 4 **A. In part. In part. Not always.**
 5 Q. You have suggested -- you have told us about the
 6 limitation issue in self-insured claims. How else are
 7 the council aiming to revisit their approach taken to
 8 civil claims as a result of this inquiry?
 9 **A. The independent inquiry have heard, this investigation**
 10 **has heard, from at least one complainant core**
 11 **participant that it was a matter of years before her**
 12 **claim was settled. I have looked -- in order to inform**
 13 **the inquiry -- at our practice over the last**
 14 **10/13 years. So 2005, there were very few claims in**
 15 **2005, but it took 12 years to settle those claims. By**
 16 **2011, it was taking on average six years. In 2017,**
 17 **those claims that were made in 2017 and settled, it took**
 18 **on average eight months. We have worked hard, I think,**
 19 **within the county council to try and expedite those**
 20 **claims, and we think that's the right thing to do,**
 21 **although we have had some suggestion it might not be the**
 22 **right thing to do so quickly as well.**
 23 Q. It might not be the right thing to do because people are
 24 still waiting to see outcomes of injuries or --
 25 **A. The impact, what the emotional or the physical impact**

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1 **A. Yes, I'm there.**
 2 Q. Given your experience, Mr Pettigrew, do you think there
 3 is a risk that records were kept incomplete or destroyed
 4 in order to cover up allegations or responses to
 5 allegations of sexual abuse?
 6 **A. I have not seen any evidence of that at all. However,**
 7 **I do understand victims/survivors' suspicion of that.**
 8 Q. Do you think the prospect of civil litigation or, again,
 9 the influence of insurers, has any bearing on the
 10 response to requests for records?
 11 **A. I don't think so. Not within the county council.**
 12 Q. When responding to claims or allegations by reference to
 13 contemporaneous records, does the county council take
 14 into account the evidence from complainants who say that
 15 records often misrepresent the true position, either by
 16 recording things incorrectly or failing to record things
 17 at all?
 18 **A. Sorry, could you say the beginning of that sentence?**
 19 Q. Yes. Would the county council take into account
 20 evidence that we have heard from complainants who say
 21 that their records, when originally entered, often
 22 misrepresent the true position at the time, either by
 23 recording things incorrectly or failing to record things
 24 at all?
 25 **A. I think the Independent Inquiry Into Child Sexual Abuse**

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1 **for the investigation into the councils of**
 2 **Nottinghamshire have heard of a culture within units**
 3 **like Beechwood where you would not be surprised for that**
 4 **to be the case.**
 5 Q. Does anyone from the council assist adults with
 6 accessing their records and making requests?
 7 **A. Yes, we do. The council has the historic abuse team.**
 8 Q. Is psychological support provided or assistance with
 9 literacy offered at that time when records are being
 10 gone through?
 11 **A. If that's identified as being something to happen and,**
 12 **you know, we can -- I can identify a case where that is**
 13 **absolutely the case, and it wasn't just so that they**
 14 **could access records, it was because of that gentleman's**
 15 **circumstances, of us letting him down when he was in our**
 16 **care in the 1960s. When he should have been at school,**
 17 **he wasn't at school; his labour was being exploited.**
 18 **We have helped him improve his literacy.**
 19 Q. In situations where we know at present a fee has to be
 20 paid for a subject access request, is the council
 21 reviewing how that might be waived in certain
 22 circumstances?
 23 **A. It may surprise you, Mr Sadd, that I wasn't aware that**
 24 **a fee was being requested from victims/survivors of**
 25 **child sexual abuse. If that's the case, I will make it**

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1 **I am now going to give that commitment. If I may just**
 2 **refer to ciphers, after the evidence of L48 in**
 3 **Trent Bridge -- it is not the first time I have met L48.**
 4 **He is someone that we have an ongoing relationship with**
 5 **because of the contribution that he makes to our social**
 6 **work training. I met him and told him that as long as**
 7 **I'm director for Children's Services, if his therapist**
 8 **continues to identify him having need, then that's what**
 9 **will happen.**
 10 Q. As we identified a moment ago, you've sat in for every
 11 day of the inquiry bar two sessions. What is it you've
 12 learnt, Mr Pettigrew, from listening to the evidence
 13 that you hadn't realised or may not have appreciated?
 14 **A. I don't think I fully appreciated the strength of value**
 15 **that an apology can make for a victim and survivor.**
 16 **I have been humbled by the experience, and it's been**
 17 **really difficult for me and others. I heard D6, and, if**
 18 **I may, Mr Sadd, say, my legal team and I are of the view**
 19 **that the most articulate person that has been on their**
 20 **feet in this hearing is D6, and God forbid that we have**
 21 **a panel like this in 30 years' time, but if we do, he**
 22 **should be sitting where Mr Frank is sitting in 30 years'**
 23 **time. He is clearly a very able young man, and the**
 24 **local authority with responsibility for his aftercare**
 25 **and perhaps some of the people in this room now should**

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1 **my priority to get that stopped.**
 2 Q. Page 88, please, of your statement, paragraph 5n.14. In
 3 the Gallagher case, one of the Serious Case Review
 4 recommendations related to support to the victims
 5 involved in the case. They were offered support and
 6 counselling. Do you know, Mr Pettigrew, what the take up
 7 was for support and counselling?
 8 **A. I will confirm. I have it in my head that we are still**
 9 **in touch with six victims and survivors of that case.**
 10 Q. Do you know whether the council experienced that some of
 11 the victims, or any of the victims, had any reservations
 12 about accepting support from the council?
 13 **A. I don't know that.**
 14 Q. Can you understand how reservations might be expressed?
 15 **A. I would understand that, yes. One of the reasons that**
 16 **we, with some claims, have settled, including a fee for**
 17 **counselling, is so that the victims/survivors can go and**
 18 **find that support themselves.**
 19 Q. One issue that was raised with Steve Edwards is about
 20 continued funding of counselling for complainants. Are
 21 you in a position today to assure complainants that you
 22 will make every effort to continue to make funding
 23 available for as long as it is required?
 24 **A. Mr Sadd, you have heard Mr Edwards give that commitment,**
 25 **you have heard Councillor Owen give that commitment.**

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1 **help him get back on his feet and get back on a path of**
 2 **academia. He is clearly a gifted young man.**
 3 **What I would also, and I do want to say this, is**
 4 **that D6 -- and I can only assume it came from one of his**
 5 **legal team or someone in the team -- in describing the**
 6 **reaction at the end of Tuesday, the first Tuesday,**
 7 **Day 2, at Trent Bridge, described council officers as**
 8 **being "stoney faced". It wasn't my face that whoever**
 9 **communicated that to him was looking at, because if they**
 10 **were, they would have seen my lips tremble and my eyes**
 11 **fill. Nor was whoever communicated that to D6 with me**
 12 **in Asdas in West Bridgford when my wife phoned me and**
 13 **I tried to talk about the victim and survivor L -- no,**
 14 **it wasn't, apologies, I think it was C21, the gentleman**
 15 **who came in and said, "I entered this room as a victim,**
 16 **I'm leaving as a survivor". I couldn't get the words**
 17 **out. I sobbed in the aisles of Asdas.**
 18 Q. Mr Pettigrew, thank you for your patience with me. You
 19 are now going to be asked a series of questions by two
 20 different counsel representing core participant
 21 complainants.
 22 **A. Mr Sadd, may I at some point -- will I get the**
 23 **opportunity to respond to the suggestion that we have**
 24 **got it wrong in the county with regards to the**
 25 **historical abuse team? Or would you like me to put that**

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1 **in writing?**
 2 Q. Respond to it quickly now.
 3 **A. I'm disappointed and surprised for the suggestion that**
 4 **we have got it wrong. My lack of surprise is, I have**
 5 **always taken the view that other local authorities may**
 6 **have a different approach, but it's a different**
 7 **approach, and respect and being respectful of that**
 8 **different approach. I was disappointed to hear that it**
 9 **was a view of another local authority that our approach**
 10 **was wrong.**
 11 **I do believe that children and social workers can**
 12 **support vulnerable victims and survivors of child sexual**
 13 **abuse and it's not lost on me that Rachel Morton has**
 14 **left the HAT team to join an adult community mental**
 15 **health team.**
 16 MR SADD: Mr Pettigrew, as I say, you will be asked some
 17 questions by other counsel.
 18 **A. Thank you.**
 19 **Examination by MS GALLAGHER.**
 20 MS GALLAGHER: As you know, I represent 45 victims and
 21 survivors, including D6. May I start by just saying
 22 thank you on behalf of D6 for the words you have just
 23 said, which are much appreciated. Can I also say thank
 24 you for the indication you have given in relation to
 25 fees and charges in respect of records. That was

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1 discretion, the guidance doesn't ban them from being
 2 local employees?
 3 **A. No, and I think that Birmingham have piloted the IRO**
 4 **service being attached to Cafcass. I think that's**
 5 **a different lack of independence. I'm sure other**
 6 **organisations are available.**
 7 Q. The key point just is, it is local discretion about how
 8 it is managed, so despite the name, in fact the way it
 9 is placed within the organisational structure is left up
 10 to the local authority?
 11 **A. That's right, and in Nottinghamshire County Council, the**
 12 **IRO service is not part of Steve Edwards' service**
 13 **department. It sits within Laurence Jones' service**
 14 **department which is separate. They are both line**
 15 **managed by me.**
 16 Q. That's where I was going to go next. Because at
 17 paragraph 7ef.34 -- it is a bit complicated -- which is
 18 at page 137, you describe the IRO team. I was going to
 19 ask you about who directly line manages it and who
 20 ultimately line manages it, but you've answered that.
 21 **A. It comes to me as the director of Children's Services.**
 22 Q. Certainly, but can you just help us with where it sits
 23 within the structure below you?
 24 **A. I can, yes. So I have three service directors reporting**
 25 **to me: one who is responsible for children's social care**

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1 a question we had asked counsel to the inquiry to put on
 2 behalf of our clients and it is very important to them.
 3 In the short amount of time I have, I am going to
 4 deal with two topics with you. The first thing I want
 5 to ask you about concerns independent reviewing
 6 officers, IROs. If you want to orient yourself, it's in
 7 your statement at pages 136 to 137. You have got a few
 8 paragraphs about IROs there. The first thing I want to
 9 ask you is really about national guidance, so nothing to
 10 do with your council specifically.
 11 Mr Pettigrew, the very name of IROs indicates that
 12 they are independent, but do you agree that the IRO
 13 national guidance, some of which you have summarised in
 14 your statement, only defines that in terms of IROs need
 15 to be independent from the line management of cases and
 16 not being responsible for preparing the child's care
 17 plan?
 18 **A. That's correct.**
 19 Q. The statutory guidance doesn't have any prescription --
 20 **A. That's correct.**
 21 Q. -- does it, about where the IRO service should be placed
 22 within the organisational structure?
 23 **A. That's correct.**
 24 Q. Including whether IROs, for example, should be local
 25 authority employees? That's left up to local

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1 **and other fieldwork services, such as family support.**
 2 **That's Steve Edwards, who the investigation has heard**
 3 **from. The second person -- or a second person is**
 4 **a service director for education in schools, which isn't**
 5 **material to your question. Then the third person is**
 6 **someone who is responsible for the commissioning and**
 7 **performance management. He also manages the team that**
 8 **supports the local Safeguarding Children's Board,**
 9 **quality assurance, so the quality assurance --**
 10 Q. That's where IROs fit in your structure?
 11 **A. The IROs fit in there with Laurence Jones. I understand**
 12 **that may not be independent enough in some people's**
 13 **eyes, but it's more independent than some other local**
 14 **authorities.**
 15 Q. Thank you. That's exactly where I wanted to establish
 16 with you, where you sit on the scale of independence, if
 17 I can put it that way.
 18 Can you assist us with this: being within that
 19 structure, where do they actually physically sit in the
 20 council building?
 21 **A. There are many council buildings, because of the size of**
 22 **the county. The county is 800 square miles. They sit**
 23 **in County Hall --**
 24 Q. It is my fault for asking such an open-ended question.
 25 **A. They sit in County Hall where there are no fieldwork**

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1 **social work teams.**
 2 Q. That's precisely the question I wanted to come to.
 3 Thank you very much. So they don't share a space with
 4 fieldwork social work teams?
 5 **A. No.**
 6 Q. I'm very grateful. Thank you. In your statement you
 7 refer to there being 14 equivalent full-time IROs.
 8 Could you just help us with this: does that mean some of
 9 them are part time?
 10 **A. Yes.**
 11 Q. Do you know how many IROs there are in total?
 12 **A. Not at hand but I can find that out and provide that in**
 13 **our written submission.**
 14 Q. I would be grateful. It's just because in that
 15 paragraph -- I can just tell you the point -- you then
 16 say:
 17 "Each individual IRO holds cases of between 50 to 65
 18 children."
 19 What we wanted to know is, is that on the full-time
 20 equivalent, is that 50 to 65 across the 14 notional
 21 full-time equivalents, or is that 50 to 65 across
 22 a larger number which may include some people working
 23 part time?
 24 **A. I understand the question and I will submit it in**
 25 **writing.**

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1 Q. Is that something you agree with?
 2 **A. Yes.**
 3 Q. The next paragraph down, I just wanted to draw your
 4 attention to a quote from Lord Justice Jackson there
 5 where he says:
 6 "I have suggested elsewhere that the comforting
 7 cliché of the IRO as the local authority's 'critical
 8 friend' should be discarded. If IROs are going to do
 9 their job properly, they should be neither friends nor
 10 enemies of their fellow professionals -- they should be
 11 independent."
 12 Do you agree?
 13 **A. If you are asking me for a corporate position,**
 14 **Nottinghamshire County Council's position, I have only**
 15 **just seen this last night. I would have to go away and**
 16 **consult on that and come back. If you are asking me for**
 17 **a professional view, I'm relatively agnostic. I think**
 18 **it is time for a national review. You will know as**
 19 **well, Ms Gallagher, that there's a third report.**
 20 Q. Yes, that's right.
 21 **A. I think Ms Michalska referred to that,**
 22 **Sir Martin Narey's fostering stocktake.**
 23 Q. You will know we can't do follow-up questions, so
 24 I couldn't engage with her in a dialogue about it, but
 25 we are of course aware of it.

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1 Q. Thank you very much. Are you aware, Mr Pettigrew, that
 2 the House of Lords Committee on Adoption Reform in 2013
 3 made a recommendation that the government should
 4 implement section 11 of the Children and Young Persons
 5 Act 2008 to employ IROs outside the local authority? It
 6 was recommendation 24, but it was rejected by the
 7 government. Are you aware of that?
 8 **A. I'm aware of that, yes.**
 9 Q. Are you aware of a 2014 review of IROs conducted by the
 10 National Children's Bureau in Loughborough University?
 11 **A. I am and you reminded me of it yesterday evening when**
 12 **I received the documents but I haven't had a chance to**
 13 **go through it yet.**
 14 Q. No problem. It's just one thing I wanted to pull up on
 15 screen just to get your comment, Mr Pettigrew.
 16 INQ002948. If we could pull up page 5, please. Just so
 17 you can see what this is, this is a foreword to the
 18 report. It is by, at the time, Mr Justice
 19 Peter Jackson, now Lord Justice Peter Jackson. I just
 20 want to draw your attention to a couple of quotes in it.
 21 Do you see the third paragraph down:
 22 "The independent reviewing officer must be the
 23 visible embodiment of the commitment to meet our legal
 24 obligations to this special group of children."
 25 **A. Yes.**

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1 **A. He offers an alternative view.**
 2 Q. That's right. I hear you, you are agnostic on it.
 3 That's no problem.
 4 **A. Although where we may have common ground,**
 5 **Sir Martin Narey's view may be reflective of what the**
 6 **IRO service is like within the local authority rather**
 7 **than what it might be like if it were, I suspect, what**
 8 **you would describe as truly independent.**
 9 Q. Yes. You may be hearing more about this tomorrow. Let
 10 me put it that way. Second topic, and I will do it
 11 quickly, I see the time. I want to ask you with
 12 reference to a particular document just a few short
 13 questions.
 14 Do you agree that the historic evidence suggests
 15 that there were multiple failures in the past by your
 16 council which resulted in children being abused with
 17 impunity and in many cases being unable to disclose? Is
 18 that something you accept?
 19 **A. I accept that there was a systemic failure by**
 20 **Nottinghamshire County Council -- the combined**
 21 **Nottinghamshire County Council during the 70s, 80s and**
 22 **90s. I think we will continue on occasion to fail**
 23 **children individually, but as I sit here now, I don't**
 24 **think there's systemic failure within our children's**
 25 **homes or within our foster care. I think we are**

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1 **becoming more alive to harmful sexual behaviour. If we**
 2 **had more time --**
 3 Q. Could I just on that note -- I'm just conscious I have
 4 a question to ask and I'm going to get a note any moment
 5 saying "Stop talking", and I want to put this question.
 6 Is that okay? I'm sorry, because I do appreciate what
 7 you are saying.
 8 **A. No problem.**
 9 Q. Do you agree, Mr Pettigrew, that those historical
 10 failures included these three things: number one, social
 11 workers not seeing children alone? Do you agree --
 12 **A. Yes.**
 13 Q. -- historical failures, the evidence shows that?
 14 Secondly, allegations of possible sexual abuse or
 15 inappropriate contact not being taken seriously?
 16 **A. Yes, systemically, yes.**
 17 Q. Thirdly, poor record keeping and a lack of oversight.
 18 Do you agree they are three themes which have emerged
 19 from the historical evidence?
 20 **A. They were three themes which emerged from the historical**
 21 **evidence, yes.**
 22 Q. I take it you are aware of this -- it's in tab 18 of
 23 your bundle.
 24 **A. It is, yes.**
 25 Q. It is the August 2017 Nottinghamshire Safeguarding

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1 **"Does that not show that these three themes appear in**
 2 **this case?", I would say, yes, it does in this case.**
 3 **However, that's at the same period as this organisation**
 4 **was inspected by eight inspectors over four weeks. They**
 5 **didn't find that in the case. They found the children**
 6 **were being seen alone, in this case.**
 7 Q. So you say this is a failure in this individual case, it
 8 is not systemic. Is that your answer to this case?
 9 **A. Today, yes.**
 10 Q. Can you assist us just with this, given the time: the
 11 NSCB report, just one further paragraph that I will take
 12 you to quickly, it's paragraph 176 on that page. You
 13 will see why it is important for something later. If
 14 you can have 175 and 176 on the screen, it would be
 15 helpful. Paragraph 175 finds that serious allegations,
 16 a number of serious allegations, were not reported to
 17 the police by social workers in this case, doesn't it?
 18 Then paragraph 176, there is a specific issue there --
 19 **A. The most serious allegation that the child of rape**
 20 **was --**
 21 Q. That's where I'm going. Paragraph 176:
 22 "The allegation of rape by one of the boys was
 23 discussed by the police and social workers although it
 24 was only social workers who undertook any formal
 25 enquiries ..."

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1 Children Board report in the case of Perry, a neglect
 2 case. You're aware of that?
 3 **A. Yes.**
 4 Q. Can I take you to a few short paragraphs in relation to
 5 that. I'm conscious you may need to say something more
 6 detailed subsequently, but in the minute we have left,
 7 can I take you to some of it?
 8 **A. Yes.**
 9 Q. That's a case, isn't it, where the Serious Case Review
 10 was concerned with the appropriateness of professional
 11 support given to a 15-year-old boy diagnosed with
 12 serious injury in April 2015?
 13 **A. I'm sorry, but the report does not --**
 14 Q. Sorry, it is a 15-year-old child.
 15 **A. Thank you.**
 16 Q. A 15-year-old child named Perry in the report arising
 17 from emotional abuse and neglect?
 18 **A. Yes.**
 19 Q. Can I take you to a few paragraphs. It is
 20 INQ002951_032: it is paragraphs 171 to 173 here. First,
 21 Mr Pettigrew, paragraphs 171 to 173. Didn't the
 22 Safeguarding Children Board find that social workers
 23 failed to see the children alone and failed to act on
 24 the father controlling access to the children?
 25 **A. Ms Gallagher, if where you are taking me is to say,**

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1 That finds, doesn't it, that social workers were
 2 inappropriately delegated by the police to investigate
 3 and that that shouldn't have happened?
 4 **A. That's the finding of the Serious Case Review and**
 5 **I accept the finding of that Serious Case Review.**
 6 MS GALLAGHER: Thank you very much. I'm grateful for your
 7 time. I have nothing further.
 8 MR SADD: Chair, I know it is envisaged that Mr Simblet is
 9 going to be asking some questions for ten minutes. I am
 10 conscious again of the time. Are you happy that he will
 11 allowed to continue?
 12 THE CHAIR: Yes.
 13 MR SIMBLET: Thank you, madam. I will be shorter if I can.
 14 Examination by MR SIMBLET
 15 MR SIMBLET: Mr Pettigrew, I'm asking you specifically about
 16 the civil proceedings involving L17. You have been to
 17 look back over those, haven't you, because I think you
 18 were describing that. She gave live evidence to the
 19 inquiry. She was sexually abused in Beechwood and
 20 Amberdale in the late 1970s and '80s, including being
 21 sexually abused by Colin Wallace. Now, Colin Wallace
 22 had been dismissed in 1980 and had been subsequently
 23 charged and convicted of abuse of somebody else, but was
 24 known to be an abuser. Is that right?
 25 **A. So I understand.**

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1 Q. Her letter of claim went to the council in 2011?
 2 **A. It did.**
 3 Q. It took six years until her claim was settled, didn't
 4 it?
 5 **A. It did.**
 6 Q. The council disputed everything, didn't it? It argued
 7 about limitation?
 8 **A. So I understand, yes.**
 9 Q. It required her to prove that she'd been abused, even
 10 though it was known that Colin Wallace had been
 11 a convicted abuser?
 12 **A. And that's wrong, yep.**
 13 Q. It disputed the psychiatric damage, and she gave
 14 evidence about that, didn't she?
 15 **A. So I understand.**
 16 Q. You say these things are wrong. It's been the
 17 consistent approach of the council in other cases,
 18 hasn't it?
 19 **A. It has historically, yes.**
 20 Q. You have signed defences requiring people to prove these
 21 things, supporting the defence of limitation and
 22 requiring proof of the abuse, haven't you?
 23 **A. When I first arrived, yes, I was given a bunch of**
 24 **defences to sign, yes. I have subsequently and since**
 25 **then on occasions refused to sign defences to that end.**

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1 **A. Sorry, claimed 3.**
 2 Q. That's not in fact correct, actually, but we'll --
 3 **A. Sorry, that's what I have been advised.**
 4 Q. You're keen to make these points about what you say are
 5 the legal fees. Basically, by the council acting in the
 6 way that it does, disputing things when people are known
 7 to have been abused, and so on, they inflate everyone's
 8 costs. Are you saying that victims of child abuse
 9 shouldn't have skilled lawyers to help them, just in the
 10 same way as the council pays for skilled lawyers?
 11 **A. No, I'm not. What I'm saying is, we need to find a more**
 12 **effective way through that settles these claims quicker,**
 13 **at better value to the victims and survivors, without**
 14 **the situation where the legal -- on both sides -- costs**
 15 **are greater, significantly greater, than the award**
 16 **that's given to the victims/survivors.**
 17 Q. Were you hoping that the victims/survivors would give up
 18 and become demoralised?
 19 **A. Myself, absolutely not, and nor do I think the**
 20 **county council. If you have any evidence of that,**
 21 **please let me know and I will address that.**
 22 Q. It is expensive and distressing to all sides to continue
 23 these things, but the council has protracted -- this
 24 isn't the longest, is it, there are some of seven years
 25 we heard about --

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1 Q. I was going to ask you --
 2 **A. But I am here as a corporate witness. The**
 3 **county council is working in the circumstances that it**
 4 **has.**
 5 Q. We all heard --
 6 **A. What I wouldn't accept, Mr Simblet, is that delay is**
 7 **only caused by one side of the fence.**
 8 Q. We all heard and we are all grateful for the words you
 9 have said this afternoon, no doubt, that you hope that
 10 the attitude will change, and so on. You say you have
 11 spoken to insurance -- your insurers about this sort of
 12 stance. Have you thought of changing insurers or
 13 insisting that different positions are taken in your
 14 cases?
 15 **A. I don't think we could change insurers for a historic**
 16 **case.**
 17 Q. No, in the future going forward?
 18 **A. Our insurance changes all the time.**
 19 Q. All right. So you would accept, would you not, that six
 20 years was far too long?
 21 **A. I think it is ridiculous that we have a situation where**
 22 **a case takes six years to settle, where the**
 23 **victim/survivor, for every pound that she received, that**
 24 **her solicitors received 3.**
 25 Q. Well, that's --

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1 **A. I think I said 12 years.**
 2 Q. You said you're as frustrated as anyone else. That's
 3 probably not quite right, is it, because she said it was
 4 like being abused again, and it no doubt would be,
 5 having to go and speak to independent psychiatrists and
 6 things, and have your account minimised, wouldn't it?
 7 **A. I will check the transcript this evening. If I said**
 8 **I was as depressed as anyone else --**
 9 Q. Frustrated as anyone else?
 10 **A. As frustrated as anyone else, yes. I would accept that**
 11 **my frustration would be nothing like that of**
 12 **the victim/survivor. If that's what I said, I would**
 13 **retract that.**
 14 Q. Can I move on to the apologies and so on? You were kind
 15 enough to volunteer an apology to L17 at the hearing,
 16 weren't you, and you went to see her?
 17 **A. Yes, yes. That it was done at the hearing was at her**
 18 **choice. I approached an IICSA member of staff to say**
 19 **that I have heard the compelling evidence of L17, that**
 20 **it is clear that an apology is still important to her.**
 21 **I made the offer of making that apology there and then,**
 22 **if that's what she wanted, or at a future date at her**
 23 **convenience, with whoever she wished to be present.**
 24 Q. Yes. To be fair, Mr Pettigrew, I wasn't making any
 25 criticism of you.

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<p>1 A. I'm not suggesting you are, Mr Simblet.</p> <p>2 Q. But you did, during that apology, make the complaint you</p> <p>3 have made now, that legal fees are often very expensive</p> <p>4 in these cases, didn't you? You said it to her during</p> <p>5 the apology?</p> <p>6 A. I can't recall doing that. I'm reminded I'm under oath,</p> <p>7 but I genuinely can't recall doing that. Mr Ratcliffe,</p> <p>8 her solicitor, was present.</p> <p>9 Q. You now are prepared to -- I think you've made an even</p> <p>10 broader guarantee than that in the evidence you have</p> <p>11 given this afternoon, so it may not be worth pursuing</p> <p>12 this point in detail, but you will support her, as you</p> <p>13 have offered, in any counselling and support that she</p> <p>14 needs going forward, and that's not just about your</p> <p>15 tenure, are you in a position to bind the council if you</p> <p>16 left?</p> <p>17 A. No, of course I'm not. Actually, the question that</p> <p>18 Mr Sadd went, to the best of our ability -- I can't</p> <p>19 remember, I will check the transcript, but it wasn't an</p> <p>20 absolute guarantee and I'm not in any position to give</p> <p>21 that absolute guarantee. What I did offer L17 is,</p> <p>22 I would find her the appropriate way of finding</p> <p>23 a pathway to meet her needs. I have done that. I have</p> <p>24 continued to pursue that. I have confirmed my apology</p> <p>25 in writing.</p> <p style="text-align: center;">Page 181</p>	<p>1 Q. You have.</p> <p>2 A. I am told by Mr Ratcliffe that L17 doesn't wish to</p> <p>3 receive that from him yet until the end of</p> <p>4 the proceedings.</p> <p>5 Q. She is no doubt going to be grateful when she gets that.</p> <p>6 The counselling and support you will put in place as</p> <p>7 best you can when she is able to take it?</p> <p>8 A. I will find her the correct way of accessing counselling</p> <p>9 and support. L17, you will recall, in her evidence has</p> <p>10 said she hasn't found counselling helpful to date.</p> <p>11 MR SIMBLET: Thank you very much.</p> <p>12 MR SADD: Chair, I wonder if you or your colleagues have any</p> <p>13 questions?</p> <p>14 THE CHAIR: There is only one question, from Mr Frank.</p> <p>15 Questions by THE PANEL</p> <p>16 MR FRANK: I wonder if you could help me understand, I got</p> <p>17 a very clear sense from what you have said to us the</p> <p>18 frustration that you feel about the civil system of</p> <p>19 settling things being unsatisfactory, not just from the</p> <p>20 point of view of the claimant, which we have heard, but</p> <p>21 also from your point of view. You have found it</p> <p>22 frustrating when perhaps a defence is put forward which</p> <p>23 you don't think is appropriate. You have spoken about</p> <p>24 the clear view that you have about your relationship</p> <p>25 with your lawyer, namely, you will get advice from them</p> <p style="text-align: center;">Page 182</p>
<p>1 and ultimately it is your decision. But you also told</p> <p>2 us, and I think I recall you saying there was a question</p> <p>3 of some confusion about whether it was the tail or the</p> <p>4 dog, because -- is this the position, that you have been</p> <p>5 given to understand that, once a claim is made under</p> <p>6 what is sometimes called the legal doctrine of</p> <p>7 subrogation, the insurer steps into the shoes</p> <p>8 technically of the insured and then decides how the case</p> <p>9 is progressed? Is that the sort of thing you had in</p> <p>10 mind when you talked about the frustration you felt</p> <p>11 about that?</p> <p>12 A. I think that's accurate, Mr Frank, yes.</p> <p>13 MR FRANK: It would be helpful if you were able to do so --</p> <p>14 not today, because you will need to reflect on it -- if</p> <p>15 you could give us a little bit more detail about that</p> <p>16 because, clearly, if you feel that, as an experienced</p> <p>17 and professional person, it may be that that's</p> <p>18 information that would be of help to us in coming to any</p> <p>19 conclusions we have about how the civil system may be</p> <p>20 improved.</p> <p>21 A. Mr Frank, if it assists you, yes, I will do that in</p> <p>22 writing. The last thing that Nottinghamshire</p> <p>23 County Council wants to do is to be involved in another</p> <p>24 line of investigation by the Independent Inquiry for</p> <p>25 Child Sexual Abuse. We have had some association with</p> <p style="text-align: center;">Page 183</p>	<p>1 children in custody because we have a secure children's</p> <p>2 home and we have had some association with children</p> <p>3 migrants because of the sponsorship of</p> <p>4 the county council, the Children Migrant Trust.</p> <p>5 However, we think that our experience is so rich with</p> <p>6 regards to this area that we should be contributing to</p> <p>7 future seminars all around with regards to reparation.</p> <p>8 MR FRANK: Thank you very much. I'm grateful.</p> <p>9 MR SADD: Chair, that completes Mr Pettigrew's evidence.</p> <p>10 (The witness withdrew)</p> <p>11 MR SADD: Would you be happy to resume at 3.40 pm?</p> <p>12 THE CHAIR: Yes. Thank you very much. Thank you,</p> <p>13 Mr Pettigrew.</p> <p>14 (3.24 pm)</p> <p>15 (A short break)</p> <p>16 (3.40 pm)</p> <p>17 MR SADD: Chair, the last witness of today is Chief</p> <p>18 Superintendent Robert Griffin. His statements are at</p> <p>19 NTP001536 and NTP001692.</p> <p>20 MR ROBERT GRIFFIN (sworn)</p> <p>21 Examination by MR SADD</p> <p>22 MR SADD: Good afternoon, Chief Superintendent. You have</p> <p>23 provided two statements on behalf of</p> <p>24 Nottinghamshire Police. The first is dated May 2018,</p> <p>25 and the second is dated 2 July 2018. Both are signed</p> <p style="text-align: center;">Page 184</p>

1 and dated, and at the time that you signed these
 2 statements, were you satisfied that they were true to
 3 the best of your knowledge?
 4 **A. Yes, I was.**
 5 Q. Are there any corrections that you want to make?
 6 **A. No, thank you.**
 7 Q. As you will have heard me say to other witnesses, but it
 8 includes your evidence as well, copies of your statement
 9 are with the panel and both those statements will be
 10 uploaded to the website over the course of the next few
 11 days. As you again have heard me say to other
 12 witnesses, I am not going to take you through, line by
 13 line, your statements, but we are going to move from
 14 topic to topic, and these are topics that you have been
 15 advised about that I will be discussing with you.
 16 **A. I understand.**
 17 Q. You're chief superintendent with -- can I call it the
 18 Notts Police? Do you mind? Is that all right?
 19 **A. Yes, you can.**
 20 Q. You have been with the Notts force for 22 years.
 21 Between April 2016 and November 2017, you were head of
 22 Public Protection, and you were promoted to your present
 23 position in December 2017. At paragraph 4, you tell the
 24 inquiry that you were -- are responsible, I should say,
 25 for Operation Equinox and indeed you undertook the

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1 set out in your first statement at page 25,
 2 paragraph 92, to page 31, paragraph 122, a chronology of
 3 the training delivered to officers investigating the
 4 sexual abuse of children. I may have missed it in your
 5 statement, but is there any specific training for
 6 officers working within Operation Equinox on dealing
 7 with historic child abuse sex allegations?
 8 **A. There is not any training that's specific for officers
 9 dealing with non-recent cases, no.**
 10 Q. You say at paragraph 122 that your team have been unable
 11 to find any training packages or programmes that relate
 12 specifically to the sexual abuse of children in care.
 13 Given the extent of your experience now in working in
 14 Equinox, do you think such a training programme ought to
 15 exist?
 16 **A. I think we would welcome one, yes. We have a number of
 17 training packages that run through various sexual
 18 offences, and do include, of course, sexual offences
 19 against children, but a package that deals specifically
 20 with investigating non-recent cases of child sexual
 21 abuse, I think we would welcome that, yes.**
 22 Q. Chief Superintendent, the inquiry has received a number
 23 of accounts of non-recent sexual abuse relating to
 24 children and their time in care, but specifically
 25 against other children in residential care and other

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1 review that I took Yvonne Dales to which you carried out
 2 when you were DI Griffin in 2013; is that right?
 3 **A. I was actually DCI Griffin at that time.**
 4 Q. Forgive me, DCI Griffin. You have provided the
 5 corporate statement for the force and I think I am right
 6 in saying you have sat in on every day of the inquiry's
 7 hearings here and in Nottinghamshire?
 8 **A. With the exception of one. I had to miss last Friday.**
 9 Q. We are going to look first at the approach to non-recent
 10 allegations. The inquiry, chief superintendent, has
 11 heard evidence about the difficulty in obtaining some
 12 social care records. At times these are incomplete,
 13 sometimes they may have been written by members of staff
 14 against whom the allegations are made. This is
 15 reflected in the Beechwood suspect collusion report
 16 which we are going to go to later.
 17 What impact does this have on investigations into
 18 non-recent sexual abuse, this issue with the records?
 19 **A. So investigations of this nature are difficult per se
 20 because we often seek corroboration, and that
 21 corroboration we hope to find in records. So firstly,
 22 of course, we need those records to exist, and,
 23 secondly, then we need them to be accurate.**
 24 Q. On the issue again of the approach taken to the
 25 investigation of allegations of non-recent abuse, you

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1 children in foster care households, so the harmful
 2 sexual behaviour issue. Have you detected any
 3 reluctance to investigate or prosecute these cases
 4 because the alleged suspect was a child at the time?
 5 **A. In my experience in the workplace, or do you mean
 6 throughout this inquiry?**
 7 Q. Throughout this inquiry.
 8 **A. I don't think I have sensed a reluctance to investigate,
 9 no.**
 10 Q. Has the approach to these cases, that is, the harmful
 11 sexual abuse cases, developed during Daybreak and
 12 Equinox? Has it grown more sophisticated, for instance?
 13 **A. It has, yes. I think it's important at this stage to
 14 explain that Operation Daybreak and then Xeres, which
 15 together became Equinox, they don't deal with all
 16 harmful sexual behaviour between children, non-recent
 17 cases. Equinox, or Daybreak, was first set up to deal
 18 with offending within institutions, primarily committed
 19 by those caring for children in care. If we encounter
 20 a complainant within that investigation who has also
 21 been the subject of abuse by another child whilst
 22 they're in care, then that is an investigation that is
 23 undertaken by Equinox. If it is outside of those terms
 24 of reference, then that now goes into the wider Public
 25 Protection Unit where it's investigated by the adult**

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1 **team, assuming that the complainant is now an adult.**
 2 Q. Can we look next, please, at the resourcing of
 3 Operation Daybreak. I think you were present when
 4 DI Dales gave her evidence?
 5 **A. I was, yes.**
 6 Q. But to summarise that, she said that she was initially
 7 only able to dedicate one day per week to Daybreak and
 8 that in hindsight it should have had a full-time SIO.
 9 She also said that she didn't have enough experienced or
 10 skilled members of staff to deal with an investigation
 11 on the scale it was, and that, overall, the
 12 investigation, in her view, was not sufficiently
 13 resourced. Indeed, I think her evidence was, until
 14 2015, she was only able to devote one day a week to
 15 Daybreak. Do you accept her criticisms?
 16 **A. I do. I think at the point that it was realised by our**
 17 **organisation, related to the scale of that**
 18 **investigation, that that was wholly inadequate – and**
 19 **I hope my view on that is reflected in a report that**
 20 **I wrote in November 2014, when I was asked by the force**
 21 **to consider what an investigative team ought to look**
 22 **like in relation to more allegations that were by that**
 23 **time emerging in relation to care homes in the county.**
 24 Q. What impact, in your view, did this failure of resource
 25 have on the investigation overall?

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1 **operational decision taken by our chief constable at**
 2 **that time. I think the chief constable was of the view**
 3 **that Mr Pearson had taken several decisions that the**
 4 **chief constable wasn't content with. I think the chief**
 5 **constable was of the view that those decisions were**
 6 **likely to have an impact on the investigation, and, for**
 7 **that reason, the chief constable took a decision to**
 8 **replace him.**
 9 Q. We heard evidence from Rhona Hicks last week that after
 10 Patrick Gallagher's conviction, further allegations of
 11 child sexual abuse were made against him, and the
 12 decision was taken to give him a caution in relation to
 13 those allegations. The police have now disclosed the
 14 MG3 which provides the rationale for that decision to
 15 caution. That's at NTP001696. In essence, the
 16 rationale was that Gallagher had already received the
 17 maximum sentence with a minimum tariff of 28 years in
 18 relation to his guilty plea following his conviction,
 19 and that the options available after that were between
 20 cautioning and a decision to take no further action. Am
 21 I right about that?
 22 **A. Yes, they appear to be the options that were considered**
 23 **by the Crown Prosecution Service at that time, yes, and**
 24 **that's quite apparent from the MG3, yes.**
 25 Q. Is there anything that you want to add to that?

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1 **A. I think the impact probably relates to the pace of**
 2 **the investigation; I'm of the opinion that it has not**
 3 **impacted the number of prosecutions, which I think has**
 4 **been suggested at one point in the inquiry.**
 5 Q. Between 2011 and 2015, should the inquiry conclude,
 6 Officer, that there was a failure at a senior level to
 7 take Operation Daybreak seriously?
 8 **A. My view -- so decisions had been taken at that time by**
 9 **senior officers within the organisation. That's quite**
 10 **apparent. I think those decisions were taken based on**
 11 **a number of factors: so at that time, there were obvious**
 12 **other demands on the force; the police service has**
 13 **finite resources; there were children making**
 14 **contemporaneous reports; and of course all the crime**
 15 **types that we have to deal with. When you couple that**
 16 **together with, I think, a lack of understanding of**
 17 **the nature and the complexity of this type of**
 18 **investigation, in the way that we now know it, when you**
 19 **put those things together, I think that is what results**
 20 **in the decisions that were taken at the time.**
 21 **So it might be slightly unfair to call it a failure.**
 22 Q. Can you explain, on a slightly different issue, but very
 23 specific, do you have any understanding why it was that
 24 Adrian Pearson left Operation Equinox?
 25 **A. The short and simple answer is that it was an**

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1 **A. I first learnt of that after Rhona had given her**
 2 **evidence last week. When that came out in the evidence,**
 3 **I was really surprised to hear that that would be a**
 4 **disposal, for a man like that in respect of a crime like**
 5 **that. It appeared on the face of it as if the police**
 6 **had taken that decision and it was that, really, that**
 7 **caused us to explore that in some more detail.**
 8 **I have read the MG3 now and I see what the Crown**
 9 **Prosecution Service decided. I can express a personal**
 10 **view on that. My personal opinion is that he could have**
 11 **been charged with those offences. I'd go a step**
 12 **further, if I might, and say he should have been**
 13 **charged.**
 14 **Now, the impact and outcome of being charged might**
 15 **not have made all that difference in terms of sentence,**
 16 **in fact, it probably wouldn't have made any. He would**
 17 **no doubt have pleaded guilty, because he'd admitted the**
 18 **offences. He would have therefore probably pleaded**
 19 **guilty very early and been sentenced. But those**
 20 **sentences would have been concurrent sentences,**
 21 **I suspect, in those circumstances. But the impact of**
 22 **a conviction through the eyes of a survivor has to be**
 23 **different to the impact of a caution.**
 24 Q. And for that reason, you think that, looking at it
 25 through the eyes of the survivor, that conviction would

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1 have been important?
 2 **A. It's difficult to try and put myself in the shoes of**
 3 **the prosecutor that made that decision. But when I have**
 4 **read that MG3 and when I consider the facts of that**
 5 **case, from my perspective, I think it would have made**
 6 **a really big difference, and it's something that, had**
 7 **I been involved in the case at the time, I would have**
 8 **pushed for, and I actually can't see why it didn't**
 9 **happen.**
 10 Q. Can we please go to tab 7 of your bundle. This is
 11 NTP001654. If this could be brought up on screen. This
 12 is a suspect collusion report that was prepared
 13 in May 2018 in relation to Beechwood. It was
 14 commissioned not by you, but by the SIO of
 15 Operation Equinox; is that right?
 16 **A. It was, although following a discussion with me, yes.**
 17 Q. If we go to page 2, please, we see under "Aim":
 18 "The purpose of this report is to try and identify
 19 whether any collusion took place between suspects
 20 carrying out sexual abuse against children whilst
 21 working at Beechwood as members of staff during its
 22 period of use and whether any collusion could be
 23 considered to be a paedophile ring."
 24 For the purposes of the police investigation, how is
 25 a paedophile ring defined?

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1 "The combined results support the hypotheses that
 2 a small and limited level of collusion may have taken
 3 place between suspects, but the evidence is not robust
 4 enough to support the existence of a paedophile ring."
 5 Are you in a position to expand a little on that?
 6 **A. Yeah, I think, first and foremost, the title of**
 7 **the document is unhelpful. We didn't choose the word**
 8 **"collusion", the analyst did, and I think in hindsight**
 9 **that's a mistake. That's the first thing. Because what**
 10 **we were really looking for here was any evidence of**
 11 **conspiracy. With the analysis that's been done, which,**
 12 **frankly, is the investigation itself, so the vast**
 13 **majority of the evidence in this case, in this**
 14 **investigation, is in the form of witness statement and**
 15 **in the form of care records. We don't have the benefit**
 16 **of mobile phones or computers, all those other types of**
 17 **evidence that we would go to to see whether agreements**
 18 **have been entered into between suspects.**
 19 **So when it talks of, in the conclusion, there being**
 20 **evidence, or might be an inference, of collusion, and**
 21 **I have had several conversations with the analyst post**
 22 **the completion of this report, what it really tells us**
 23 **is two things. I think the first thing is that some of**
 24 **these suspects were present and working there at the**
 25 **same time, ergo, had the opportunity to offend together;**

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1 **A. We would consider a paedophile ring to be a conspiracy.**
 2 **So, in effect, the crime of conspiracy, which is where**
 3 **a group of people enter into an agreement to commit**
 4 **a particular offence -- in the context of this case,**
 5 **that offence being to abuse children -- would make out**
 6 **a paedophile ring.**
 7 Q. We can see that the six suspects that were considered to
 8 be part of a potential paedophile ring are identified on
 9 page 2.
 10 **A. They are, yes.**
 11 Q. The only one who it is possible to name is John Dent.
 12 **A. Yes.**
 13 Q. Then we go, please, to page 5, and we can see under the
 14 heading "NO-F29", the report says in that paragraph
 15 there:
 16 "He appears to be the most prolific former member of
 17 Beechwood staff with 34 individual allegations of sexual
 18 abuse from 33 different former residents, all of whom
 19 are male."
 20 What does the number of "individual allegations"
 21 mean?
 22 **A. It means that's the number of people that made an**
 23 **allegation against him.**
 24 Q. The conclusions are to be found at page 6 at the bottom
 25 of the page, where the report says:

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1 **but in terms of the number of allegations made against**
 2 **them where others were present, so that the inference**
 3 **could be drawn that they were acting together, are very**
 4 **few and, therefore, doesn't support, on the face of it,**
 5 **the existence of a paedophile ring.**
 6 Q. The number of non-recent allegations covered in the
 7 report, particularly those against NO-F29, suggest,
 8 Officer, that there was an issue with children failing
 9 to report abuse to police. Do you have a view on that?
 10 **A. As to whether there was or there wasn't?**
 11 Q. As to whether there was or there wasn't, yes?
 12 **A. There most certainly was not. To make my answer clear,**
 13 **my view is that children were not reporting, if that's**
 14 **the question.**
 15 Q. Is it possible, looking at the way -- or the evidence
 16 that we have heard about children's response at the time
 17 to the police and the confidence in being able to do so,
 18 do you think that the police bear any responsibility for
 19 that inability at the time to disclose?
 20 **A. I think it's a very difficult one for me to answer. But**
 21 **I think what we've heard a lot of evidence of in this**
 22 **inquiry is perception, and I think sometimes with**
 23 **perception we try to defend ourselves and explain to**
 24 **victims and survivors, which isn't always helpful,**
 25 **because, if that's the perception, that's the**

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1 perception. And if we have caused that perception, then
 2 the reason that victims and survivors aren't reporting
 3 to us is because they don't trust us. It's difficult to
 4 say that that's our fault, but I think it's a factor,
 5 that trust is a factor, and if trust is a factor, then
 6 it contributes to the conclusion that I think you're
 7 suggesting.

8 Q. In cases of this type, what can be done to encourage
 9 trust?

10 A. I think the way that we have evolved over the course
 11 of -- over a long period of time, but particularly since
 12 the inception of Operation Equinox, we are one of not
 13 very many forces now to have established a dedicated,
 14 non-recent child abuse investigation team.

15 Just so the panel are clear, that isn't a team
 16 that's dedicated just for the duration of while it
 17 currently sits within Equinox, but our chief constable
 18 has now established that team so that it will continue
 19 beyond. So I think that's a step towards gaining some
 20 trust. I think the more people that we prosecute and
 21 the more people that we convict, I think some of
 22 the believing actions that officers are starting to
 23 show -- there's a long, long way to go with those
 24 actions, but by listening to people, taking people
 25 seriously, behaving professionally, making sure we keep

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1 abuse team under Equinox, of her view of what she
 2 considered to be the misalignment between police and
 3 social care investigations, including the police making
 4 delayed referrals to the team and interviewing
 5 complainants alone. Are you aware of these issues?

6 A. I wasn't until Ms Morton gave her evidence, no.

7 Q. Do you accept that such a misalignment takes place?

8 A. I'm afraid I have to disagree with that evidence.
 9 I learnt of that for the first time sitting in the
 10 inquiry. It probably won't surprise the panel to know
 11 that I have been away and made some enquiries of my own
 12 about that. The SIO in this case, who I work really
 13 closely with and meet regularly with, Rob McKinnell,
 14 sits in the same building -- in fact, the same room --
 15 as the HAT team. He has regular meetings with those
 16 social workers and managers. He attends a multi-agency
 17 implementation group which until recently was monthly,
 18 it's now bi-monthly. Social worker managers from that
 19 group attend the SMG. It's never been escalated to me
 20 and, had it been an issue, then I would have expect it
 21 to have been.

22 Q. The inquiry has heard evidence from L43, who disclosed
 23 the incident of sexual abuse perpetrated upon him by
 24 another child in care in Beechwood in 2002. I think you
 25 have a copy of the transcript from 3 October when he

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1 people up to date, all those kinds of things which
 2 I would consider collectively to be believing actions
 3 I think will all serve to increase trust.

4 I think joining -- when I took the decision to join
 5 the survivors' support group, I think that was a fairly
 6 big step towards improving trust. I think it's really
 7 important now that that keeps going beyond the inquiry.
 8 I might get an opportunity at the end to talk about
 9 options -- recommendations that I might wish to make to
 10 the panel about that, because I think the more that we
 11 can get victims and survivors involved, why wouldn't we
 12 want to use their voices to inform the way we deliver
 13 services?

14 Q. How does that trust translate to children who are in
 15 care as at today and their perception of the police's
 16 role and their ability then to disclose to the police?

17 A. I think the two things are probably inextricably linked.
 18 If we provide a high quality of service to victims and
 19 survivors of non-recent abuse, but maintain the high
 20 level of service that we are providing to
 21 contemporaneous reports by children, if we put those two
 22 things together, I think that will contribute to that
 23 confidence continuing.

24 Q. Officer, the inquiry has heard evidence from
 25 Rachel Morton, a social worker within the historical

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1 gave evidence. We don't need to turn to it. In
 2 summary, he alleges that no-one from the police came to
 3 speak to him after he made his disclosure. After
 4 a while, when he was in court for something totally
 5 different, he was taken to a police station, he was
 6 asked to give a video interview but didn't provide
 7 evidence and said that he didn't want to take the
 8 further any further. He says he was told by a member of
 9 staff at Beechwood that if he "pressed charges", he
 10 would likely be moved from Beechwood and to L43 this
 11 meant the prospect of moving further away from his
 12 mother.

13 He says that he contacted the police recently to
 14 re-open the criminal complaints he made against the
 15 other child but that he was told during a phone
 16 conversation with the police, "You didn't want to press
 17 charges, sorry, there is nothing we can do to help you.
 18 The interview is not going -- it's got nothing to do
 19 with your compensation claim".

20 Where a child had previously decided not to proceed
 21 with an allegation of sexual abuse, is that a bar to
 22 them taking that up now?

23 A. No, it's not.

24 Q. On the face of it, should there have been an
 25 investigation into these allegations?

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<p>1 A. There should have been, yes.</p> <p>2 Q. I'm going to take you through the case of D6, whom the</p> <p>3 inquiry has heard evidence from about the abuse he</p> <p>4 suffered in foster care. During his time in foster</p> <p>5 care, he was moved to Yorkshire and the Isle of Wight</p> <p>6 whilst under the care of Nottingham City Council. D6</p> <p>7 said that he contacted the police last year when he had</p> <p>8 more information about what had happened to him. He</p> <p>9 informed the police that there had been previous</p> <p>10 investigations which had come to nothing. He said that</p> <p>11 the police wanted to take his statement, but he wasn't</p> <p>12 ready yet, and asked for more time. But in the</p> <p>13 meantime, the police officer spoke to the other children</p> <p>14 who had made allegations and invited the alleged</p> <p>15 perpetrator, NO-F70, for an interview, making him aware</p> <p>16 of the nature of the allegations made against him. He</p> <p>17 said -- this is D6:</p> <p>18 "So any evidence of his interests, he had plenty of</p> <p>19 time to dispose of it, prepare a defence."</p> <p>20 D6 went on to say that in June 2018, Notts Police</p> <p>21 passed the investigation to an officer in</p> <p>22 North Yorkshire Police, apparently having misunderstood</p> <p>23 that D6's abuse happened in the Isle of Wight, and D6</p> <p>24 said this in evidence:</p> <p>25 "It was just clear that it wouldn't come to anything</p> <p style="text-align: center;">Page 201</p>	<p>1 from the outset. There's just a fundamental flaw in how</p> <p>2 it's handled, particularly when you're in foster care</p> <p>3 and you're moved around. You're often out of county.</p> <p>4 The systems aren't built to accommodate the kind of</p> <p>5 investigation that needs to be accommodated."</p> <p>6 Officer, what systems, if any, are in place to deal</p> <p>7 with cases that cross constabulary borders like D6's?</p> <p>8 A. So we have Operation Hydrant, which is a national</p> <p>9 policing operation which was set up to co-ordinate and</p> <p>10 support British policing's response to non-recent</p> <p>11 allegations. Each time a report is made into a police</p> <p>12 service, the police service share that with Hydrant and</p> <p>13 one of their many roles is to ensure that they</p> <p>14 deconflict -- I will explain what I mean by that -- they</p> <p>15 deconflict reports being made in various police services</p> <p>16 so that a sensible agreement can be reached over which</p> <p>17 of those police services is to take primacy in the</p> <p>18 investigation.</p> <p>19 Q. In your view, Officer, having heard these accounts in</p> <p>20 relation to L43 and D6, is there more that Notts Police</p> <p>21 could, or should, have done for them?</p> <p>22 A. In relation to D6? I don't fully understand the various</p> <p>23 reports that D6 has made, but what I would expect is</p> <p>24 that any officer in Nottinghamshire who takes a report</p> <p>25 from somebody, even if that is to inform them that they</p> <p style="text-align: center;">Page 202</p>
<p>1 have investigations ongoing elsewhere, I would expect an</p> <p>2 officer to make contact with an officer in that host</p> <p>3 force, find out who it is that is investigating, and</p> <p>4 just ensure that that line of communication is confirmed</p> <p>5 before ceasing contact with the survivor. And I accept</p> <p>6 that that doesn't appear to have happened here, which is</p> <p>7 not good enough.</p> <p>8 Q. From having observed the inquiry and seen some</p> <p>9 historical documents, do you think that the police</p> <p>10 historically view children in care as damaged</p> <p>11 individuals, so that allegations would not be taken</p> <p>12 seriously or properly investigated?</p> <p>13 A. I think that the way that the police approach children</p> <p>14 in care now is just very, very different to the way that</p> <p>15 they approached children then. I try to put myself into</p> <p>16 the minds of officers back then, and it's difficult for</p> <p>17 me to understand. But there is a high volume of</p> <p>18 evidence that would indicate that that's how survivors</p> <p>19 felt.</p> <p>20 Q. Outside of the existing specialist Child Abuse</p> <p>21 Investigation Unit and Operation Equinox, do you have</p> <p>22 any concerns that that attitude still exists amongst the</p> <p>23 police?</p> <p>24 A. I don't have those concerns, no.</p> <p>25 Q. Can we look at some findings in recent inspection</p> <p style="text-align: center;">Page 203</p>	<p>1 reports. At tab 3, there's NTP001510. The HMIC</p> <p>2 National Child Protection Inspection published</p> <p>3 in February 2015. This made a number of critical</p> <p>4 findings, Officer --</p> <p>5 A. Sorry to interrupt you. Which tab am I?</p> <p>6 Q. Sorry, tab 3. I should have watched to see what you</p> <p>7 were doing. It is my mistake. I want to go, please, to</p> <p>8 page 16, the third bullet point there. I will give you</p> <p>9 an opportunity to get there. The third bullet point</p> <p>10 reads:</p> <p>11 "In a case involving an allegation by a 10-year-old</p> <p>12 boy in foster care that he had been sexually assaulted</p> <p>13 by another 10-year-old boy, there was no record to show</p> <p>14 that either of the boys had been spoken to by police,</p> <p>15 leaving them both at risk of further harm."</p> <p>16 Then we go, please, to page 16, and -- sorry, still</p> <p>17 there. Below the third bullet point and penultimate</p> <p>18 paragraph, there are delays in limited case supervision:</p> <p>19 "There were delays of three months or more in some</p> <p>20 cases sent to the Crown Prosecution Service for review</p> <p>21 and decisions on charging."</p> <p>22 Page 28, the first paragraph. I will give you</p> <p>23 a chance to read there. That found:</p> <p>24 "Although Nottinghamshire Police expressed</p> <p>25 commitment to child protection and inspectors found some</p> <p style="text-align: center;">Page 204</p>

<p>1 encouraging developments, much more needs to be done." 2 Then at pages 30 to 31 of the report, a number of 3 recommendations were made, including greater attendance 4 at Child Protection Conferences, reviews of supervision 5 and management of child protection referrals, and that 6 discussions should be held with the CPS to "improve 7 timeliness of actions and decisions by both the police 8 and CPS". That's page 31, the first line. 9 Then we go, please, to tab 4 of your bundle, keeping 10 those conclusions in mind, and we look at NTP001512. 11 This is a follow-up investigation completed by HMIC and 12 reported in February 2016. This report found that 13 important steps had been taken to implement some of 14 the recommendations, but others had yet to be 15 implemented. So if we go to page 10, please, and we 16 look under "Summary of post-inspection review findings" 17 and we go to the last sentence there: 18 "Inspectors were concerned to find that 19 Nottinghamshire Police had not undertaken an audit of 20 child abuse and sexual exploitation cases to improve 21 standards." 22 Then at page 11, the third paragraph: 23 "We were concerned that nonspecialist staff such as 24 front-line officers were investigating child protection 25 cases without having received training in how to manage</p> <p style="text-align: center;">Page 205</p>	<p>1 them effectively." 2 Officer, in relation to that issue about the audit 3 of child abuse and child sexual exploitation cases, has 4 that since been done? 5 A. It has been done, yes. 6 Q. Are front-line officers still investigating child 7 protection cases without having received training? 8 A. No, they are not. 9 Q. Following these reviews, we understand that the police 10 produced the document at tab 6 which is NTP001538. We 11 can see on the right-hand column under column "C", where 12 it says "Recommendation status" -- do you have that? 13 This is page 1, "National Child Protection 2014/2015 14 Recommendations"? 15 A. Sorry to interrupt, but can I just explain that the way 16 that it appears in my bundle, the pages don't follow and 17 it is not in A3, so I have actually brought a copy that 18 puts it back onto A3. 19 Q. Okay. 20 A. So if you just talk me to where I need to be, please. 21 Q. That's helpful. We are simply on the first page of your 22 A3, and we read across from left to right. We can see 23 at the very top there are letters "A", "B", "C". Do you 24 have that? This is at the very top. "A", "B", "C" 25 representing the columns?</p> <p style="text-align: center;">Page 206</p>
<p>1 A. Unhelpfully, my A3 copy doesn't, but, yes, I can follow 2 which is columns "A", "B", "C". 3 Q. It is a very simple issue, column C, "Recommendation 4 status". We can see written in some of the boxes 5 "closed"? 6 A. Yes. 7 Q. Where actions are closed, does it mean that they have 8 been addressed? 9 A. Yes. 10 Q. Who monitors the progress of those issues having been 11 addressed? 12 A. The deputy chief constable. 13 Q. What action has been taken, Officer, to improve the 14 timeliness of charging decisions by the police and CPS 15 in respect of child sexual abuse cases? 16 A. There's a fairly lengthy answer to this, because -- do 17 I have the time to -- can I start and see how we go? 18 Because what happened following this inspection is 19 a whole review of our Public Protection arrangements in 20 Nottingham. When I took over Public Protection in 2016, 21 I read these reports then, and I have read them again 22 recently, in preparation for this inquiry, and, frankly, 23 the passing of time doesn't soften the blow when I read 24 those documents. They are very disappointing. 25 So those recommendations since that time were dealt</p> <p style="text-align: center;">Page 207</p>	<p>1 with. We asked for a peer review to come and look at us 2 to try and help support us in how we might implement 3 these recommendations. 4 Very specifically on the subject of timeliness, 5 timeliness was connected to investment of resource into 6 Public Protection. There is a lot of reference in these 7 documents to child abuse being under-resourced, and we 8 put that right. We are fully engaged now with the CPS 9 at various and including very senior levels -- 10 Q. Can I help you along with your answer? 11 A. Sure. 12 Q. I don't mean to cut you short -- 13 A. Not at all. 14 Q. -- but I'm conscious of the time? 15 A. Sure. 16 Q. My question to you was whether in fact timeliness had 17 improved. Has it improved? 18 A. Yes, it has improved, yes. 19 Q. Has it improved to your satisfaction? 20 A. My satisfaction would be that once an investigation is 21 complete, the file is delivered that day to the Crown 22 Prosecution Service and they will be able to advise on 23 that day, which is an unrealistic expectation. So 24 I think that with the resources that we have and with 25 the resources that the Crown Prosecution Service have,</p> <p style="text-align: center;">Page 208</p>

<p>1 I would say that, yes, they have improved to my 2 satisfaction. 3 Q. I'm not going to get up on screen, but at tab 5, 4 NTP001515, Lancashire Police carried out in August 2016 5 a peer review of Notts Police. They found "real 6 strength" within the staff, "positive relationships" 7 with social care from some teams, but they also made 8 some criticisms. 9 A. They did. 10 Q. At page 9, the third paragraph, a criticism was: 11 "There is an apparent culture around Public 12 Protection that officers who work on the teams are 13 restricted or on reduced hours and work in a 'pink and 14 fluffy' department." 15 Does that culture still exist? 16 A. No, I don't think it does -- sorry, let me rephrase: it 17 most certainly does not, no. 18 Q. Still with page 9 and the third paragraph, the second 19 line: 20 "It was clear that each and every team works in 21 silos and there is little understanding about what staff 22 in the Public Protection arena undertakes." 23 Again, does that remain an issue? 24 A. No, it doesn't. Can I just explain the context of this 25 inspection?</p> <p style="text-align: center;">Page 209</p>	<p>1 Q. Yes. 2 A. This inspection, this peer-to-peer review, was asked for 3 by me, and as a follow-on to the HMIC inspections at 4 a time when I took over in the department. They were 5 then used as a platform to completely restructure the 6 Public Protection Department and one of the things that 7 I set out to do, and I'm really confident that I have 8 achieved, is that that whole silo working has now gone. 9 The department was considered to be a silo within 10 the force, and areas of business within it were 11 considered to be silos within silos. I think we have 12 completely removed that, and the force now I think has 13 a much more holistic approach to vulnerability, and that 14 the right resource is deployed to the right offence type 15 and investigation. 16 Q. Another criticism made, at page 12, for instance: 17 "Staff reported significant delays in sexual 18 offences cases being sent to the CPS for review and 19 decision around charges. We were informed that senior 20 officers had raised such issues with the CPS but the 21 problem continued." 22 Then, at page 17: 23 "Significant concern regarding staffing levels of 24 the PP team." 25 Page 18:</p> <p style="text-align: center;">Page 210</p>
<p>1 "... staff dealing with child protection were under 2 pressure and managing high levels of work, comments such 3 as, 'We are waiting for something like Baby P to 4 happen'; 'We feel at the bottom of the pile'; 'For the 5 first time, I have noticed that people are unhappy'; 6 'Members of staff are in tears all the time' and 'People 7 are looking externally for other jobs', appeared 8 commonplace." 9 Has the morale improved? 10 A. Yes, it has. I don't fall out with or disagree with -- 11 in fact, quite the contrary, I embrace all that is said 12 in this peer-to-peer review and I feel, as a result of 13 the restructure that followed, the vast majority of 14 those things have been put right. 15 Q. This will include, presumably, in relation to page 10: 16 "It was of concern that there was no child sexual 17 exploitation standard operating procedure or action plan 18 in place." 19 Officer, we have heard evidence from complainant 20 core participants about the approach taken to CSE when 21 they were in care. Children who were being sexually 22 exploited were treated in the past as offenders rather 23 than as victims of crime. Do you accept, from what you 24 have heard, that that appears to have been the case? 25 A. I accept that that was at that time the case, yes.</p> <p style="text-align: center;">Page 211</p>	<p>1 Q. Is there now a CSE standard operating procedure or 2 action plan in place? 3 A. Yes, there is. It's described in some detail in our 4 response to recommendations to the HMIC, which followed 5 the inspection and then the subsequent peer-to-peer 6 review. Can I take you to that? Would you like me to 7 take you to it? 8 In short and simple terms, the answer is: yes. We 9 developed from all of this work what's called 10 a 4 Ps Plan, the 4 Ps standing for prepare, protect, 11 prevent and pursue, and within each of those headers 12 a whole series of actions in order to improve our 13 response to child sexual exploitation. That came into 14 play fully in 2016 and it is just an organic document 15 which we keep working with and on. 16 Q. Can we turn, finally, to the issue of support for 17 complainants as it exists now and in the future, 18 including this issue that you will be very familiar 19 with, having attended the inquiry, of liaison and 20 communication. 21 Your statement sets out the policies in covering 22 support for complainants of child sexual abuse, and, as 23 you will have heard, evidence from complainant core 24 participants is that they have not always been followed 25 in practice, is how they feel.</p> <p style="text-align: center;">Page 212</p>

1 What are the mechanisms for monitoring these
 2 policies of communication so that you are in a position
 3 to evaluate how well they are being used in practice?
 4 **A. Which policies are you referencing, sorry?**
 5 Q. This is in relation to support for complainants and
 6 contact with complainants.
 7 **A. Yeah, okay. So I think one of the challenges that we**
 8 **face still within our organisation is that we have got**
 9 **a lot of policies and a lot of procedures, and in each**
 10 **of them there is reference to support for survivors,**
 11 **there is reference to how we conduct investigations, and**
 12 **so on. But what we don't have is a singular reference**
 13 **document that talks about non-recent cases.**
 14 **In terms of scrutiny around support now, I think we**
 15 **have got a really robust process which starts on a daily**
 16 **basis, where every case that comes into the organisation**
 17 **is reviewed by the DCI in their morning meeting, once**
 18 **a week by the detective superintendent, once a month in**
 19 **the operational performance review, once a month in the**
 20 **force operational performance review, and so that goes**
 21 **on up and through the organisation. I think, in**
 22 **addition to that, our victim satisfaction surveys that**
 23 **take place and also, from the multi-agency perspective,**
 24 **in sitting under the Children Safeguarding Boards, in**
 25 **the quality assurance subgroups, audits of these cases**

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1 **A. So the Victim Codes of Practice gives us some guidance,**
 2 **and what it says is that victims will be updated**
 3 **regularly and that a victim contract will be drawn up.**
 4 Q. How long has that been in place?
 5 **A. I can't remember the exact year, but between five and**
 6 **ten years. What the code makes clear, and something we**
 7 **are really keen to follow, is that contact -- and that's**
 8 **the frequency and means by which -- needs to be agreed**
 9 **with the victim/survivor. So we have heard some**
 10 **evidence about victim/survivors being updated via text**
 11 **message, which, on the face of it, sounds incredibly**
 12 **unpalatable, but actually, that's what some**
 13 **victims/survivors prefer. Others meet in person, others**
 14 **by writing, others over the telephone.**
 15 Q. Officer, I am conscious there are others queuing up
 16 behind me to ask you questions. I'm going to end, so
 17 there are some questions I'm not going to be able to
 18 cover with you. I just wanted to know what steps, if
 19 any, have you taken to engage with victim and survivor
 20 groups?
 21 **A. Well, I took a decision to attend the victim/survivor**
 22 **group which, prior to that, there was no police officer**
 23 **in attendance. I couldn't understand why we weren't**
 24 **there, if I'm frank about it.**
 25 **In terms of me being able to make decisions over how**

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1 **that take place.**
 2 Q. Officer, where there are failures, are they best
 3 explained by a lack of understanding by officers in
 4 involved, by lack of time and resources or by other
 5 factors? What's your view?
 6 **A. I think there are many factors. I think what we have**
 7 **heard in this inquiry is that one size does not fit all.**
 8 **So we have heard some quite contrasting evidence on one**
 9 **particular point, for example, where -- in respect of**
 10 **the approach that we, the police, make when we want to**
 11 **go and make an approach to a potential victim/survivor.**
 12 **We have heard evidence from one victim/survivor saying**
 13 **that a cold-call, as it was described, from the police**
 14 **actually turned out to be the best thing that had ever**
 15 **happened to them, which is in stark contrast to another**
 16 **victim/survivor who said that it was the worst thing**
 17 **that could have ever happened to them.**
 18 **So I think that probably constitutes a lack of**
 19 **understanding on our part, but I also think it's**
 20 **a really complicated issue, and hopefully something that**
 21 **might come out of this inquiry is some -- are some**
 22 **recommendations and some advice on how we might look to**
 23 **make that better for the future.**
 24 Q. Is there a protocol for notifying complainants of
 25 the updates on their cases?

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1 **we deliver our service, the service of the police**
 2 **service, what better way is there to inform that than to**
 3 **listen to victims and survivors, and that's why**
 4 **I decided to go.**
 5 Q. Are you still attending?
 6 **A. Yes.**
 7 MR SADD: Officer, you are going to be asked some questions.
 8 Thank you for your time.
 9 Examination by MS GALLAGHER
 10 MS GALLAGHER: Hello, Officer. As you know, I ask questions
 11 on behalf of 45 victims and survivors represented by
 12 Slater & Gordon, Instalaw and Bhatia Best, and I will be
 13 about ten minutes, just so you are aware.
 14 The first thing is, you were asked earlier by
 15 Mr Sadd about training, and you said you would welcome
 16 a specific training package. Could I just ask you
 17 something very particular about that? As we understand
 18 it, a number of police forces now use children who have
 19 been detained in police cells, in training, when they
 20 are trying to understand children's engagement with the
 21 criminal justice system. Do you agree that a similar
 22 system with survivors of child sexual abuse would assist
 23 the police in understanding and improving its standards
 24 and consistency and practice and also indeed building
 25 trust?

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<p>1 A. I can see that there is a part to play for victims and 2 survivors in helping us to develop training packages, 3 yes. 4 Q. Thank you. The second thing I just want to touch on 5 concerns a very particular issue. You have obviously 6 been here every day. You will be aware, Officer, of 7 course, that there have been some delays in updating 8 complainants, including some core participants here? 9 A. Yes. 10 Q. You accept, do you, that some of your officers have 11 failed to keep complainants updated on the progress of 12 investigations, including, indeed, a number of those who 13 were due to give evidence in week 1. I'm thinking in 14 particular of P16. 15 A. That I've agreed that they failed to keep them updated? 16 Q. You agree there was a failure in keeping P16 updated in 17 relation to the progress of his investigation? 18 A. Sorry, yes. Yes. 19 Q. Thank you. 20 A. Sorry, yes, absolutely, yes. 21 Q. I'm conscious you have accepted it privately. You 22 understand why, for the record, we wanted to establish 23 it? 24 A. Quite. 25 Q. In the table -- I think you have a table which</p> <p style="text-align: center;">Page 217</p>	<p>1 summarises those who haven't given oral evidence and 2 haven't had their evidence read. It is at your tab 15. 3 I don't ask for it to be pulled up, given the time. But 4 have you had a chance to go through that, Officer? 5 A. The table? 6 Q. The table. 7 A. I have read the table several times, yes. 8 Q. I'm grateful. You will have seen in that that there is 9 a number of people who say that they haven't been 10 updated, including D33, D5, P18 and P15 and D10. You 11 have seen those? 12 A. Yes, I have seen those, yes. 13 Q. So you accept that there has been a problem in some 14 cases with keeping people updated? 15 A. Yes, I do agree with that, yes. 16 Q. Thank you. What steps are you going to take to address 17 that? 18 A. I am going to take all of what I have heard and learnt 19 from this inquiry back into our organisation and just 20 reiterate that message. The policies and procedures are 21 there for us. They make it -- they are pretty clear. 22 They are not difficult to follow. But policies and 23 procedures are worthless without proper leadership and 24 that's what I intend to commit to when I go back into 25 the organisation.</p> <p style="text-align: center;">Page 218</p>
<p>1 Q. Thank you, Officer. Now, earlier in questions from 2 counsel to the investigation there was some discussion 3 about the issue of trust. Can I just ask you some 4 issues in relation to that. You were obviously present 5 for the read evidence in week 1 in which P3 and D46 6 described in some detail their lack of trust in the 7 police. Just to remind you, it said P3 has not 8 disclosed her abuse to the police. That's P3 having 9 been abused in the 1970s in Vale View, as she says: 10 "My current support worker advised me not to report 11 to the police because she felt the police would let me 12 down. I have heard lots of bad things about how the 13 police have handled people's cases, so I don't know if 14 this is something I want to put myself through." 15 Similarly, D46 has not reported abuse to the police, 16 abuse in Farmlands in the 1990s by older boys. He says: 17 "I feel like nothing has changed. It would still be 18 my word against theirs." 19 Do you accept, Officer, that this lack of 20 confidence/trust in the police remains a barrier to 21 disclosure for P3, D46 and others? 22 A. I agree. I agree that lack of trust and confidence is 23 a barrier, yes. 24 Q. We heard in answer to some questions from Mr Sadd 25 earlier your reference to some steps which have been</p> <p style="text-align: center;">Page 219</p>	<p>1 taken, including the dedicated non-recent child abuse 2 investigation team. Are there any specific proactive 3 steps that you're taking to deal with people like P3, 4 D46 and indeed many others in that table that you will 5 have seen? 6 A. Well, I think it goes much wider than those individuals. 7 I think that the survivor group has been a great leap 8 forward for us in terms of building trust. I think that 9 some of the issues that have been illuminated during 10 this inquiry, such as, how do we approach victims, how 11 do we keep victims updated, all those things we would 12 really welcome support and guidance going forward, and 13 I think if victims and survivors could become involved 14 as almost critical friends in helping us with that, that 15 would serve to improve trust. 16 Q. Officer, one question: a lot of your answers in relation 17 to that refer to the survivor groups. I represent quite 18 a few people who aren't in a survivor group, they are 19 individuals. They have described in that table not 20 feeling able to come forward. Are there any proactive 21 steps taken in relation to them who aren't in a survivor 22 support structure? 23 A. For those people individually? 24 Q. Yes. 25 A. Is that what you are asking? I would welcome</p> <p style="text-align: center;">Page 220</p>

<p>1 a discussion with each of them to try to talk that 2 through. 3 Q. Thank you, Officer. The next thing also relates to 4 trust. Is there any specific training or particular 5 policies within your force about dealing with 6 complainants, so child abuse victims, adults or 7 children, who themselves have significant criminal 8 records? 9 A. There aren't any policies, no. 10 Q. Is there a recognition that those individuals may have 11 particular additional difficulties in trusting the 12 police and that may cause additional difficulties to 13 them in making disclosures? 14 A. I think victims and survivors who have criminal records, 15 it's fairly obvious they have encountered the police and 16 will see the police as people who investigate crime and 17 lock criminals up. It must be difficult, therefore, for 18 them to see us as people who are likely to listen and 19 support, so I can understand that, yes. 20 Q. Thank you. So recognition but no specific policy. Is 21 that a fair summary? 22 A. Yes, I think that's fair. 23 Q. The next issue does involve a document. It is again the 24 table which I think you have there in tab 15. It is 25 page 7. This relates to a particular individual, D42.</p> <p style="text-align: center;">Page 221</p>	<p>1 It may help to have it on screen if it isn't readily 2 available for people. It is INQ002574. It's one of 3 those where the text goes off the page, if you remember. 4 I just wanted you to have it to hand. It is over 5 towards the right, a little further along. 6 So D42's experience of the police, Officer, has been 7 very poor. In summary, she disclosed her abuse to the 8 police in 2006 but a decision was taken not to charge. 9 She's repeatedly attempted to get the case re-opened and 10 the result of that is that your force issued 11 a harassment warning against her for her attempts to get 12 her abuser prosecuted. Are you able to say whether you 13 think that's an appropriate way to treat a survivor of 14 abuse? I think it is the wrong page which we have up on 15 screen, excuse me. Thank you. It's here. Thank you. 16 A. It is a very difficult question for me to deal with, 17 without knowing the context of that case. 18 Q. Of course. You may just not be able to answer now. 19 Could I have a commitment that you can look at it and 20 answer us later? 21 A. I think probably a sensible way forward would be, 22 subject to the agreement of that victim/survivor, that 23 we sit and have a conversation with them and try and 24 understand. Understand what went wrong and whether we 25 can put that right.</p> <p style="text-align: center;">Page 222</p>
<p>1 Q. I'm grateful. There is one other issue about D42 which 2 we may have to roll into that too. That is that D42 3 lawyer's were told this year, in the last few months, 4 that her 2007 statement was lost, probably destroyed, by 5 your force which she found very distressing. Again, is 6 that something you can look at and speak to D42 about? 7 A. Yes, absolutely. 8 Q. Can I then ask that we pull up on screen a document 9 which you will have seen earlier when I spoke to 10 Mr Pettigrew. That's the Perry Serious Case Review. 11 You're aware of that? 12 A. I am aware of it, yes. 13 Q. Could I ask we pull up INQ002951. Paragraph 174, first, 14 on page 32. 15 A. Which tab am I with now? Oh, it's on the screen. 16 Q. Have you got it? 17 A. I've got it on the screen. Do I need to find it as 18 well? 19 Q. I think probably on screen may be easiest. Just there, 20 you will see paragraph 174 refers to several occasions 21 when information was recorded indicating siblings could 22 be at risk from inappropriate contact or relationships. 23 If we go over the page, there is a long list. Can 24 I just point out a few of these. You will see (a), if 25 you look at (a):</p> <p style="text-align: center;">Page 223</p>	<p>1 "The youth worker reporting information ... to the 2 MASH ... that sibling 1 was talking with a 60-year-old 3 male via a social networking website." 4 Do you see that? 5 A. Mmm-hmm. 6 Q. And (c), a reference to an allegation of rape. (g), 7 a reporting about a posting on a social networking site 8 of a comment about having sex "with dad", and then (h), 9 a reference to lying in bed there with another person. 10 Is it right, if we look down, then, at 11 paragraph 175, that the vast majority of those incidents 12 were simply never reported to the police by 13 Social Services? 14 A. Much like Mr Pettigrew, I only received this document 15 late last night and, in all honesty, I haven't had 16 a chance to read it and digest it properly, which 17 I would welcome the opportunity to. Could I perhaps 18 respond to those at a later time? It's difficult, on 19 the face of it, for me to -- 20 Q. There are two separate issues. 21 A. Okay. 22 Q. One of them is, just so you know what the two points 23 are. The first one is why you weren't told, and that's 24 obviously primarily a question for Mr Pettigrew and for 25 social workers. The second issue relates to</p> <p style="text-align: center;">Page 224</p>

1 paragraph 176, and this is something I raised with
 2 Mr Pettigrew earlier, which is, one matter which was
 3 reported to the police, the Serious Case Review found,
 4 was the allegation of rape by one of the boys, and the
 5 finding in the SCR is, it was only social workers who
 6 undertook formal inquiries and it was inappropriate for
 7 the police to delegate that to social workers. Is that
 8 something you will look at, Officer?
 9 **A. Yes, I can look at that.**
 10 Q. Thank you. Finally, this is the last matter, and I will
 11 do it very quickly, there was a discussion earlier with
 12 Mr Sadd about the issue of texting people, how difficult
 13 it is to make a decision about how you deal with people
 14 and how you engage with people. Just a couple of points
 15 relating to that.
 16 The first point, Officer, I think you will accept,
 17 having been here, that many of those specific examples
 18 are not people who are upset because, unbeknownst to the
 19 police, the process that was adopted wasn't one that
 20 they wanted, it was because the process which was
 21 adopted by the police was expressly contrary to what
 22 they had asked?
 23 **A. That certainly sounds to be the case, yes.**
 24 Q. Just following on from that, in evidence this week
 25 DI Dales said there is no protocol addressing how best

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1 from me.
 2 MR SADD: Chair, do you or your colleagues have any
 3 questions?
 4 THE CHAIR: Ms Sharpling?
 5 Questions by THE PANEL
 6 MS SHARPLING: Thank you, Mr Griffin. Just one question
 7 from me. The Victims Code is being enforced in various
 8 iterations for a number of years now, I think. In all
 9 that time, has any management action been taken against
 10 individual officers or members of staff or any
 11 disciplinary action for failure to comply with it, to
 12 your knowledge?
 13 **A. I'm really unable to answer that, I'm afraid. It's**
 14 **something I can go away and find out. Our Professional**
 15 **Standards Department would hold that information. To my**
 16 **knowledge, no, but it's possible that it's the case.**
 17 MS SHARPLING: Perhaps you would be so kind to find out?
 18 **A. Absolutely.**
 19 THE CHAIR: Thank you. Sir Malcolm?
 20 PROF SIR MALCOLM EVANS: Thank you. At the outset, in
 21 response to a question from Mr Sadd, you said that you
 22 considered there to be no reluctance on behalf of
 23 the police to investigate. Do you think there is any
 24 reluctance to prosecute?
 25 **A. No, I don't think there's a reluctance to prosecute.**

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1 to make initial contact with people identified as
 2 potential victims of abuse. It is up to officers'
 3 individual judgment. Given the level of distress that
 4 you have heard here, do you accept that there should be
 5 a better system than individual officers taking
 6 a decision without guidance in circumstances where, as
 7 we have heard, many of them get it wrong?
 8 **A. So there are actually several sources of guidance, but**
 9 **they're not consolidated.**
 10 Q. Yes.
 11 **A. So there is guidance in the Hydrant SIO manual, there's**
 12 **guidance in the rape and serious sexual offences**
 13 **procedure, the child abuse -- lots of different**
 14 **references in lots of different policies, but I agree,**
 15 **a --**
 16 Q. You think it would help to strand tie?
 17 **A. A single and consolidated version of how best, I would**
 18 **welcome, yes.**
 19 Q. A strand tying protocol, in essence, which would cover
 20 both the initial cold-call in whatever format --
 21 **A. Yes.**
 22 Q. -- and also dealing with people who want to be updated
 23 about ongoing progress in their cases?
 24 **A. I would agree with that, yes.**
 25 MS GALLAGHER: Thank you very much, Officer. That's all

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1 **That's the headline answer. I think it's a really**
 2 **interesting discussion around the police opinion on when**
 3 **something is ready to prosecute versus when the CPS**
 4 **considers something is ready to prosecute, because we**
 5 **apply a very similar test, in fact almost identical**
 6 **test, so the Full Code and the public interest. It**
 7 **isn't until those two tests are passed that we would**
 8 **take a case to the Crown Prosecution Service. So it**
 9 **seems, I think, logically to follow that, at that point,**
 10 **we, the police, are of the opinion that the case ought**
 11 **to be prosecuted, but lawyers look at it through a very**
 12 **different lens, and so they should.**
 13 **I thought the evidence of Sue Matthews, either**
 14 **yesterday or the day before, I think she explained that**
 15 **test really well, the fact that she's bound by it. But**
 16 **it was one of the points that I was really hoping to get**
 17 **out, that where a decision is taken by the CPS, which,**
 18 **if it is a "no further action", is not going to accord**
 19 **with the victim/survivors' wishes -- of course it's**
 20 **not -- and it's my job and the job of my officers to go**
 21 **and explain that, which we do, and we have to do, in**
 22 **line with the code and with the law, but I wanted the**
 23 **victims and survivors to know that when we offer that**
 24 **explanation, we don't expect them to accept it, because**
 25 **it's really difficult, because where they have suffered**

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<p>1 the abuse that, without question, these survivors have,</p> <p>2 and they're brave enough to step forward and describe</p> <p>3 what's happened to them and the outcome of that is that</p> <p>4 the person who has done that to them is not going to be</p> <p>5 prosecuted, how could an explanation from somebody like</p> <p>6 me ever be acceptable to them? It's a really difficult</p> <p>7 challenge, I think, that we face. But I wanted them to</p> <p>8 understand that, from my perspective, we don't explain</p> <p>9 it expecting them to accept, but that's the explanation</p> <p>10 all the same.</p> <p>11 PROF SIR MALCOLM EVANS: Thank you.</p> <p>12 THE CHAIR: Thank you. There are no further questions.</p> <p>13 Thank you very much.</p> <p>14 MR SADD: Chair, that completes the evidence of today.</p> <p>15 (The witness withdrew)</p> <p>16 MR SADD: Chair, just to remind you, tomorrow for closing</p> <p>17 speeches and there is one witness tomorrow morning and</p> <p>18 the inquiry, exceptionally, tomorrow is starting at</p> <p>19 9.30 am.</p> <p>20 THE CHAIR: Thank you very much.</p> <p>21 (4.47 pm)</p> <p>22 (The hearing was adjourned to</p> <p>23 Friday, 26 October 2018 at 9.30 am)</p> <p>24</p> <p>25</p> <p style="text-align: center;">Page 229</p>	<p>1 INDEX</p> <p>2 PAGE</p> <p>3 PROFESSOR SIMON HACKETT (affirmed)1</p> <p>4</p> <p>5 Examination by MR SADD1</p> <p>6</p> <p>7 Submissions by MR SADD49</p> <p>8</p> <p>9 Submissions by MS GALLAGHER50</p> <p>10</p> <p>11 Submissions by MR SIMBLET51</p> <p>12</p> <p>13 Submissions by MR FORD52</p> <p>14</p> <p>15 MS ALISON MICHALSKA (sworn)53</p> <p>16</p> <p>17 Examination by MR SADD53</p> <p>18</p> <p>19 Examination by MS GALLAGHER101</p> <p>20</p> <p>21 Examination by MR SIMBLET119</p> <p>22</p> <p>23 Questions by THE PANEL124</p> <p>24</p> <p>25 MR COLIN PETTIGREW128</p> <p style="text-align: center;">Page 230</p>
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