Thursday, 25 October 2018
(10.00 am)
THE CHAIR: Good morning, everyone, and welcome to Day 14 of this public hearing. Mr Sadd?
MR SADD: Good morning, chair and members of panel. Before we start, chair, we will today be hearing evidence from corporate witnesses from both councils and the police. We are very conscious that emotions may run high during the course of this evidence. However, chair, it is important that everyone seated in the public gallery in the hearing room allows the opportunity for the witnesses to be heard and avoids interruptions. This is not just out of respect for you and the inquiry's proceedings, but also so that everyone in the hearing room, including others seated in the public gallery, can hear the proceedings properly.
THE CHAIR: Thank you, Mr Sadd. I endorse these comments. Could you now proceed?
MR SADD: Chair, the first witness we are hearing from this morning is Professor Simon Hackett. He has provided a report to the inquiry. That's at INQ002045.
PROFESSOR SIMON HACKETT (affirmed)
Examination by MR SADD
MR SADD: Good morning, Professor Hackett. You have provided a report to the inquiry. It is

dated August 2018 and it is entitled "Overview expert report on the development of the understanding of, and responses to, harmful sexual behaviours between children from 1945 to present day"; is that right?
A. That's correct.
Q. The panel have a copy of that report, and the whole of the report will be uploaded onto the inquiry's website over the next few days. I'm not going to go through it with you line by line. I intend taking you to particular topics and asking you to expand or elaborate on text that you set out there.
Some documents that are aligned with your report may be used in the inquiry's report along with some publicly available documents, and those will be uploaded over the course of the next few days. Please can we go to your report, page 1, and your professional background. You are the Professor of Child Abuse and Neglect at Durham University and have, over the last 20 years, undertaken a considerable amount of research and written a number of papers and books on the topic of harmful sexual behaviour between children. Is that right?
A. That's right.
Q. Can we go straight, then, please, to the first part of your report, the introduction. This is where you look at the prevalence of child-on-child sexual abuse. At

paragraphs 1.1 to 1.3, you address this prevalence, and it is correct to summarise it that it is generally agreed that between a third to a quarter of all sexual abuse is carried out by those under 18.
Is it difficult to establish an accurate figure because of the secrecy often involved in committing such acts and the variable ways of recording it?
A. I think both because of the secrecy and variable ways of recording it, but also because this is a problem that has only relatively recently been acknowledged and understood. So I think all of those three things mean that indicators are not entirely reliable.
Q. Page 5, please. Here you discuss the evolving terminology and the continuum, as it were, of child sexual behaviour. This is between paragraphs 2.1 and 2.18. At 2.10, the bottom of page 6, you say that it's now recognised that sexual behaviours in childhood exist on a continuum from normal and developmentally appropriate, on the one hand, to highly abnormal and violent, on the other. Indeed, at page 10 of the report, you provide a model of the span of that behaviour.
Could you explain in a little more detail, please?
A. I think it's been really important, as awareness has grown about the problem of child sexual abuse by

children, to understand that this is not one categorical issue, that actually the behaviours involved range from low-level inappropriate behaviours to highly deviant and abusive behaviours. It's important to understand that any one child who presents with problems with sexual behaviour is likely to be expressing them in different degrees over a period of time. So I think the idea of a continuum has been proposed in order to try to guide professionals to make distinctions between children's sexual behaviours and the level at which they are displayed in order to be responding commensurately with the behaviours and the risks associated with those behaviours across this idea of a continuum.
Q. We go over the page, please, to page 7, and at the bottom of the page, paragraph 2.13. There you address the distinction between abusive sexual behaviours and problematic sexual behaviours. Can you expand a little on that?
A. I think the broad definition of sexually abusive behaviours by children is taken to indicate behaviours that involve a degree of coercion, disparity of power, manipulation and harm, whereas problematic behaviours may well be those that are developmentally more appropriate but are expressed inappropriately or in inappropriate contexts, where there may be no overt

elements of victimisation or coercion but, in a sense, the behaviours are difficult and need guidance and appropriate responses because they are out of step either developmentally or poorly expressed in the wrong kind of contexts, but it would be unfair to those children expressing those kinds of behaviours to label them as abusers or demonstrating abusive behaviour because, in a sense, it's categorically and different sets of behaviours to those that might be defined as abusive.

Q. From what you have understood of present-day training and guidance, do you think that present-day residential care staff of children in care homes are able to discern that difference between the two?

A. I think, broadly speaking, there has been some developments in awareness on the range of sexual behaviours by children. Certainly in the earlier days of my own practice in the earlier 1990s on this topic, it was assumed that almost all expressions of sexual behaviour by children and young people were abusive and harmful, whereas I think now there's much more of a nuanced understanding of these behaviours, including in relation to care staff.

Q. In your view, should there still be intervention in cases identified by staff of non-abusive, problematic

behaviour?

A. I think, as with all children and young people who are having -- expressing sexual behaviours, they rely on their carers, parents, adults around them, to help guide those behaviours in order for them to be expressed safely in a way that doesn't cause problems for them or other people. So even if something is problematic or inappropriate, I think that needs professional guidance or carer guidance for young people, in order to help them to perhaps learn and develop in a healthy way sexually. That is, of course, very different from providing more intensive treatment for those children who are expressing abusive behaviour. I think that's a really important distinction that professionals, and indeed parents, need to make.

Q. Still with page 8, please, paragraph 2.15. You say:

"The term 'harmful sexual behaviour' ... is now the preferred terminology ..."

Is that the terminology that you think should be widely adopted?

A. I think so, yes, and we have moved away in the field from talking about juvenile sexual offenders or adolescents who sexually abuse to a broader understanding of these behaviours on this idea of a continuum. So harmful sexual behaviour for me is

an umbrella term that embraces behaviours that may be harmful to others but also implicitly has -- damages the child who's expressing those behaviours too. So it may be harm towards self or others. I think this is a much less stigmatising and pathologising term to use for children who may be experiencing difficulties with sexual behaviours.

Q. I think it is also your view that the term "peer-on-peer" is not appropriate to describe adolescents abusing younger children. Is that right?

A. I think peer-upon-peer abuse or peer-on-peer sexual abuse has been proposed recently to describe the subset of young people who abuse their peers, ie, children and young people of the same age as them, roughly. Of course, that's categorically a different issue to those adolescents who target and abuse much younger, pre-pubescent children. So I think we should avoid the term "peer-on-peer abuse" if what we are talking about is large age discrepancies between children.

Q. Page 9, please, where you're developing at 2.17 the use of the term "harmful sexual behaviour". You say at the top of page 9 that the issue of children and young people who sexually abuse other children no longer features in the last two versions of Working Together. We know there is a very recent version, as you identify

there, this year. Do you know why that is?

A. I'm not entirely sure why that is. I think the guidance has been perhaps broadened to look at principles -- core principles about protecting children, and perhaps this is an issue that is seen to be covered in that broader guidance, without needing to be explicitly identified in the -- certainly in the English and Welsh context. It is interesting, however, that the National Guidance for Child Protection in Scotland document does have a section on children and young people who display harmful or problematic sexual behaviour, so there are some differences between the national -- the guidance amongst the different nations within the UK.

Q. Indeed, previously in the UK, in England and Wales, it had been in the Working Together succession of documents; is that right?

A. Certainly from the 1991 version, which was the first time that they had explicitly been mentioned within Working Together, there was a section on children who harm other children.

Q. Part 3 of your report, please, page 11. Here you look at the development of awareness and understanding of harmful sexual behaviour from the 1980s to present. You discuss that development and you say at 3.3:

"Given the lack of general awareness of child sexual

abuse itself, it's perhaps unsurprising that the historical understanding of children as perpetrators was so low."

Paragraph 3.8, please, if we can move on -- that's page 13 -- you say that by the late 1980s there was still little or no discussion about the management and treatment needs of children and young people who were perpetrating sexual offences, and you note from the Masson Paper in 2000 that the problem had not been characterised or officially recognised.

Would you have expected, Professor Hackett, at that period, a local authority to have had policies or procedures on the issue by that time?

A. No.

Q. Paragraph 3.11, please, page 14. Something you have just touched on. You note that Working Together had some 30 lines -- this is Working Together 1991, I should say -- about how to deal with abuse carried out by children and young people. You understand that this was included in guidance because of a Social Services inspector who was particularly interested in the issue, that's included in the Working Together guidance. We know that the county council in Nottinghamshire had specific guidance in its own procedures in 1991. Is that something that was generally the case amongst local

authorities, as far as you're aware?

A. To the best of my awareness, local authorities at that time developed their policies and procedures in conjunction with Working Together, so I would have expected some reference within local procedures and policies to the brief guidance within Working Together at that time. That really set the framework for the first time around responses to this issue.

Q. Page 15, please, paragraphs 3.13 and 3.14. You refer there to a 1992 National Children's Homes report on children and young people who sexually abuse other children. You describe it as a landmark document. Why do you see it as that?

A. Certainly in the UK context, this was the first time that the issue had been looked at systemically and seriously, and the NCH at the time drew together expert opinion of people who, from a ground level, were very concerned about the problem. So it has reflected developing awareness of the existence of a group of children and young people who were abusing other children and this really set the context for the professional landscape at the time. It really identified for the first time the failings and the problems inherent in the child welfare system in response to this issue and set some targets for areas

that needed to be addressed.

Q. Page 16, please, paragraph 3.16. You note that the period from the mid 1990s to the mid 2000s saw a steady but not remarkable increase in awareness and knowledge about the issue of harmful sexual behaviour. Again, as we are moving on in time, what policies or procedures would you have expected a local authority to have had about harmful sexual behaviour, bearing in mind the Working Together guidance of 1991 and the National Children's Homes report that you have just mentioned? So this is looking at the period from the 1990s to the mid 2000s?

A. I think in the early or mid 1990s, guidance would largely be underpinned by the Working Together document. As research and awareness began to grow, as training courses began to be put on for local authority workers on this issue, throughout the late 1990s and early 2000s, I think we saw a bit more of a sophisticated approach to the area of work, and in my review in 2005 of the state of policy and practice with my colleague Helen Masson, we reviewed the state of policy and procedures across local authorities in the UK. We found that a majority of local areas that the time had guidance.

There was also a period of time when the

AIM Project, which is an initiative based in Greater Manchester, began to develop interagency procedures to deal with this issue from the early 2000s.

Q. AIM standing for what? Can you just remind us?

A. It stands for "Assessment, Intervention and Moving on". It was an interagency project that tried to develop procedures initially in Greater Manchester. These AIM procedures were then adopted by many local authorities from the beginning of the new millennium as a way of articulating the interagency response and bringing together Youth Justice and Child Welfare Services for joint assessments and responses to the issue.

Q. In the 2005 paper that you have just mentioned, yes, you say there was a more sophisticated approach, as you have just told the inquiry, but you say that the response from therapeutic services about the state of out-of-home care for children with harmful sexual behaviour painted "a woeful picture" of both the availability and quality of care placements and that there was insufficient specialist residential resource. In what circumstances would a child, at that period, displaying harmful sexual behaviour be provided with a specialist placement? What would be the threshold, in effect?

A. I think the thresholds varied substantially across the country, actually. Our research in the mid 2000s

painted a picture of tremendous variability in terms of the way that cases were handled and also the availability of local assessment and residential facilities. So in some cases, at that point in time, the decision to provide a specialist placement for children was a reflection of the lack of availability of local resource. So many children were placed in out-of-borough specialist placements, simply because -- not necessarily because the threshold for their behaviour was such that a decision had been made that they had to be specifically accommodated in a specialist residential provider, but because there was no suitable placement within a local area.

Q. Should the inquiry understand that "specialist" means being entirely separated from other young people, or simply more stringent supervision?

A. So specialist residential placements tend to be -- my interpretation of that term is that they are providers that only offer accommodation for children and young people who have displayed harmful sexual behaviour. These tend to be in small group homes.

Q. Do you know what the current level of provision nationally is?

A. I think more recently we have seen a growth in those kinds of specialist provision. The more recent evidence

from a review that was done by Smith and colleagues only a matter of a few years ago that updated our research from the mid 2000s continued to raise the availability and quality of specialist placements as a problem. So I think the position is still rather patchy, even though we have seen a growth of that provision in the intervening ten years.

Q. From your own research, do you have any assessment of the quality of provision?

A. Certainly in our 2005 report, when we consulted I think around about 200 respondents who were involved in this work across the UK, a very small minority were satisfied with the quality of that provision, so it was a question of a lack of availability but also, where provision was available, some concerns about its quality.

Q. And 13 years on, is the picture a better one, do you know?

A. My sense of that from working with care providers is that there is some very good quality provision around in the UK, but that's not necessarily reflected everywhere.

Q. Paragraph 3.22, page 18, please. You reflect on some of the ongoing problems identified by the NSPCC regarding the interagency response to harmful sexual behaviour, including ongoing lack of appropriate training and support for staff. What do you think can be done to

address these ongoing problems?

A. The framework that the NSPCC has published I think is a really important step forward, and this is an opportunity for local agencies to audit their practice in relation to children and young people with harmful sexual behaviours, to bring multi-agencies together in order to look at the strengths and relative weaknesses in addressing these issues, and also has promoted a sense of standardisation of practice in terms of assessment, availability of intervention services, and, importantly, training. Training I think to date has relied on rather short courses -- one-day courses provided by local Safeguarding Children's Boards -- as part of a suite of interagency training. I think we probably need to have a better system of more intensive training for those staff who are working with this issue more regularly.

Q. As you have just mentioned, still on page 18, paragraph 3.23, please, you have mentioned the NSPCC framework, and you say it's been adopted by several local authorities. Over the page, please, to page 19, paragraph 3.25. You note that at present the majority of local Safeguarding Boards acknowledge the issue of harmful sexual behaviour in procedures and documents but "despite previous attempts to encourage government to

develop a comprehensive policy on this issue, there is still no national strategy or overarching service delivery model in relation to this issue across the UK, though the NSPCC operational framework is a significant step forward towards in this regard."

To what extent, if any, do you think that the absence of a framework or delivery model impacts on safeguarding of children in residential or foster care?

A. I think obviously local authorities need, and care providers need, to take their reference point from somewhere. I and a number of other people working in this field have encouraged government, over a number of years, to try to come up with a -- demonstrate leadership by describing an operational framework that really would bring together/co-ordinate agencies to be clear in terms of responses at different levels of intensity across the UK, to really try to move beyond this rather patchwork postcode lottery that still exists in relation to availability of services. So I think that, in the absence of that, it often comes down in local areas to what services are available, whether there are trained and interested workers who have really taken this work on and have led to, from a ground-level approach, the coordination of services.

I think obviously that has resulted in some very

excellent practice in areas of the UK, but because it hasn't been led from government, there is variability in whether that's occurred across all areas in the UK.

Q. Section 4 of your report which is at page 20 we are going to come back to, but that section deals with the evolution of the criminal justice and child welfare response to the issue of sexual offences by children. I want to go, though, to section 5, which starts at page 33 of your report. If we can go, please, to paragraph 5.8 at page 35 -- do you have that?

A. Yes.

Q. You say, starting at the top of that paragraph:

"It is now recognised that pre-adolescent children with sexual behaviour problems are a diverse group with differing levels of need ... cases involving younger children should be dealt with in qualitatively different ways to those involving adolescents."

By "cases involving younger children", is this in relation to the age of the alleged perpetrator?

A. Yes.

Q. Do you think procedures are set up in such a way to allow for different responses in this way or are cases handled generically, regardless of age?

A. I think there has been a tendency to lump all children and young people who have demonstrated harmful sexual

behaviours together as if they are all -- all their behaviours are all similar with the same likely outcomes and the same motivating factors. The issue about pre-adolescent children I think is really important currently within the field because, previously, when people started to make attempts to address the issue of adolescent perpetrators of sexual abuse, we took the reference point from research primarily derived from adult sex offenders and it took us a long time to unlearn some of that, those approaches; in other words, to respond to young people as adolescents rather than as mini adults. I think we run the risk at the moment of doing the same thing for much younger children, pre-adolescents, whose motivating factors underpinning their abusive sexual behaviours are likely to be different from teenagers or adolescents. So I think there's a lesson from history there in terms of how we move forward in relation to the needs of much younger children.

To be specific, much younger children are highly likely themselves to be victims of sexual abuse and their behaviours, their abusive and problematic sexual behaviours, are much more likely to be a direct consequence of sexualisation through abuse. So the intervention response for those children should be much

more akin to that of children who have experienced victimisation rather than models of practice that have been derived on adult or adolescent sexual offenders, for want of a better term.

Q. Indeed, Professor Hackett, this is something you come on to discuss at paragraph 5.14. This is page 36. You say:

"It is now recognised that there is no one simple cause for harmful sexual behaviour in childhood."

You discuss what you describe as the most promising theoretical model of causes, and that's at page 37, please, paragraph 5.15. You say that that's described in a paper by Ward and Siegert, and they put forward five pathways which you set out at pages 37 to 38. The second pathway, which we can see at the bottom of page 37, is labelled "Distorted sexual scripts", and suggests that one pathway is that a young person can have distorted beliefs and thought processes, sometimes, as you have just mentioned, reflective of those who have been abused as younger children. Indeed, you say that should be understood as suggesting that one of the causes of those children then committing harmful sexual behaviour is that they will have been sexually abused themselves, as you have pointed out.

The inquiry has heard evidence, for example, from

a former resident of a children's home, known by L46, that she was sexually assaulted in the context of bullying. How should the inquiry understand this type of behaviour to fit into the pathways?

A. Sorry, for me to be clear, how should the inquiry understand bullying sexual behaviour?

Q. Yes.

A. I think that probably links more closely with this particular pathway about anti- social thinking that Ward and Siegert have proposed. This is often used to explain why children and young people whose experiences and backgrounds are more characterised by general criminality, rule breaking and boundary violation across different areas of their lives are sexualised during adolescence, and I guess sexual bullying is a good example of this, if you like, broader portfolio of deviance and rule breaking and boundary violation that exists within a peer group context.

Q. 5.22, please, page 39. You develop this through to 5.25. You note that it was previously assumed that the majority of adolescents who sexually abused others were at high risk of continuing to sexually offend into adulthood. But based on more recent studies, as you set out, that's no longer the understanding now. Is that right?

A. It's absolutely the understanding. This is a really important point for the inquiry to understand, that most children and young people who present with harmful sexual behaviours grow out of it by their mid 20s, so the evidence is very strong in support of this idea of adolescent-limited sexually abusive behaviour.

Q. Then we go, please, to section 6 of your report. This is where you look in more detail at the abuse histories of children -- this is page 43, I should have said, Professor Hackett. You look at the abuse histories of children who sexually abuse other children. You say, at paragraph 6.7, page 44 -- do you have that?

A. Yes.

Q. This is at the top of the page. You note that the overwhelming majority of victims of all forms of abuse do not go on to abuse others. Using the idea of a cycle of abuse to explain or predict abusive behaviour in young people you say is damaging to victims. Why damaging to victims?

A. I think for children who have lived with sexual abuse, assuming they are therefore at risk of abusing others, does a great disservice to the majority of victims who are struggling with that experience and to make their lives -- to turn their lives around as a consequence of that abuse experience. This is probably -- the

misunderstanding about this point is probably related to research that was originally done in relation to adult sex offenders in the 1970s and '80s, particularly in North America, where it was found that most adults who sexually offend began -- had themselves started to abuse when they were adolescents.

So it was therefore misassumed that those who were presenting with these behaviours in adolescence would carry on into adulthood. I think what I have tried to do in the report is to make a distinction between the fact that a history of sexual abuse in childhood might, for those children who do go on to sexually offend or abuse other children, might be explanatory. In other words, it might be the underpinning developmental experience that sets the context for that person's subsequent behaviour. But that's very different from then pathologising most victims of abuse as potential abusers. That logic doesn't follow.

Q. Indeed, that's the thrust of what you say at paragraph 6.9 on the same page. At 6.10, looking at it the other way around, as to whether those who have exhibited harmful sexual behaviour had previously been the victims of child sexual abuse. At paragraphs 6.10 to 6.12, you refer to research showing that somewhere between I think it is 25 per cent and 84 per cent of

those who exhibit harmful sexual behaviour had previously been the victims of child sexual abuse. Is there any reason for such a wide variation?

A. I think there are a range of reasons. Looking at those studies, they have used different definitions of what constitutes sexual abuse. They have also used different sources of data. Many of them have relied on case file analysis, which may not be an accurate record or it may well be, retrospectively, that people haven't asked children presenting with these behaviours about their own abuse experiences rather than talking with them directly. I think operational, definitional issues, data, methodical issues, have all accounted for this wide variety. As you will note from the table that I provide on page 45, some of the studies involve rather small numbers as well.

Q. Should there be any confidence factor percentage figure that we could rely on as a reflection of --

A. Well, of course, my own study in 2013 is by far the best, and it's the largest UK study of children and young people presenting with these behaviours. And when we looked at this, we saw about half of the young people in that sample of 700 had experiences -- either confirmed or very strongly suspected experiences -- of sexual abuse in their background. As you will note,

a significant proportion also had experienced physical abuse, et cetera.

I mean, the overwhelming message, I think, looking at -- despite the range of studies that exist, the overwhelming message is that the abuse histories and trauma histories of children who present with harmful sexual behaviours are much more elevated than you would expect in the general population. In other words, trauma is a key indicator and a key causal factor for many children about their subsequent expression of harmful sexual behaviour.

Q. Page 48, please, paragraph 6.21. You say that two-thirds of 700 cases analysed had experienced at least one form of abuse in the past and at least half of the total sample had experienced a form of abuse other than sexual. So, at 6.22, should the inquiry then conclude that children exhibiting harmful sexual behaviour are likely to have histories of general maltreatment or trauma, as you describe, but not necessarily sexual abuse?

A. I think there's a group of children whose own trauma histories may not have necessarily included sexual abuse, or at least that might not be the only form of abuse that they have experienced, where other forms of trauma have then caused them difficulties in relation to

interactions with other people, intimacy, and often those problems become sexual in nature during puberty.

Q. Page 49. Between paragraphs 6.23 and 6.25, you use the phrase "polyvictimisation". Should that be understood to be the issue that we have just been talking about? What does it mean?

A. Sorry about the jargon. This is a dreadful American term but from colleagues, respected colleagues, in the US who have used the term "polyvictimisation" to describe multiple forms of abuse in children's backgrounds, and it's been proposed that this is a really important term to understand, really, if you like, the tipping point for many children from being victims towards harming other people, that this presence of polyvictimisation, in other words, sexual abuse in the context of physical abuse, domestic abuse, neglect in their backgrounds, often poor levels of parenting, poor models, role models, in their lives. All of these factors interact to make it more likely for children to experience problems with their own sexual behaviour regulation, in adolescence particularly.

Q. We are going to move on, Professor Hackett, to section 7, but on the way there, if we go to page 51, you can see that what you have provided there is a model for explaining possible associations between

victimisation and harmful sexual behaviour. In effect, it sets out in a diagrammatic form what you have been explaining.

Section 7, please, page 52. Here you deal with the recognition of sexual abuse between children in care and what has been understood about this form of abuse since 1945 to the present day. You begin by saying that in the general literature this has not been a focus of research and therefore discussion of children in care has been restricted to looking at those with harmful sexual behaviour who are then placed in care settings as a consequence of their behaviour. This is looking by contrast -- it is not looking at those who offend for the first time whilst in care or who are victims whilst in care. I say the word "offend"; I mean who exhibit harmful sexual behaviour for the first time in care. So there is a contrast to be had there; is that right?

A. I think so, yes.

Q. Paragraph 7.5, page 53. You refer to your own study in 2013, which you have already touched on, which suggests that a third of people referred to UK services over a nine-year period then entered into the care system. At 7.9, over the page, 54, you say that, for some children whose sexually harmful behaviour is influenced by their home environment, coming into care can actually

prevent further harmful sexual behaviour. Have I understood that correctly?

A. Yes. I think one of the key distinctions about children with harmful sexual behaviours is that often their behaviours are very contextually driven and influenced by the environment in which they are living, and certainly I have seen very many examples of children who have been moved out of highly abusive and sexualised environments and put in good-quality care contexts that have effectively helped them to not express further harmful sexual behaviours. In other words, the context -- providing a safe, supportive and nonsexual care context in itself is enough to stop the further display of harmful sexual behaviour.

In addition to that, however, I think that's a really important point for many care providers, because there are examples of children and young people for whom that is not recognised in relation to attribution of high levels of risk for young people who are continued to be regarded as high risks for future sexually abusive behaviour when the evidence is not there.

Q. You describe what you call an overly risk-averse approach to children who come into care having exhibited harmful sexual behaviour before?

A. Yes. So if the prevailing thought is that most of these children and young people continue to sexually offend and will continue to sexually offend through adolescence into adulthood, then that obviously leads to a philosophy of care that is very restrictive in terms of the life opportunities of those people. If, however, the key evidence from outcome studies is that the majority of these children and young people will in effect grow out of the behaviours in late adolescence and early adulthood, then the care task becomes different, it becomes one of helping nurture young people's life opportunities in order to make sure that the restrictions placed on them don't inhibit their future chances, in terms of, say, for example, educational achievement, unnecessarily. So there is a balance to be had, I think, between risk management and protecting other people around that child, but also not squashing that child's development so significantly that it actually prevents them from moving on in their lives.

Q. My simplistic understanding is a balance between being defensive, on the one hand, and being positive, on the other, in trying to address those needs?

A. Being safe, on the one hand, and also opening up opportunities for appropriate development, on the other.

Q. Paragraph 7.11, please, page 55. You say that the assumption that young people in care are particularly prone to exhibiting harmful sexual behaviour is highly problematic, pointing out there that children in care are often subject to significantly more scrutiny and behaviour is more likely to be reported. It may be that you have already answered this question: do you think that the care setting cultivates an overly cautious approach to intervention in harmful sexual behaviour? I suspect the answer is yes, isn't it?

A. I think that children in the care system are often subject to scrutiny about their conduct, including their sexual conduct, in a way that children perhaps living in family contexts are not subject to professional scrutiny. So in some cases, I think children in the care system, when they're exhibiting normal sexual behaviours, are deemed to be displaying inappropriate or problematic behaviours, not because of the nature of the behaviours themselves, but the context in which they're expressing those behaviours. So sometimes the problem is the context, not the behaviours itself, and that's, I think, a really important distinction to make.

Q. From your experience and research, do you think it's difficult for residential care staff and foster carers to work out whether a child's sexual behaviour is normal

experimentation, on the one hand, or abusive, on the other?

A. I think it is a problem for care staff, but also more broadly within society, that adults struggle to understand what is normal and abnormal in relation to expressions of children/adolescent sexual behaviour across the board, and particularly with the changing nature of sexual interactions between children, the use of online sexual interactions, et cetera, these are all things that mean that there's long since been problems for adults in trying to work out and support children at different levels, and that I think includes care staff. They're often placed in very difficult situations of having to manage sexual interactions between children in a care setting without a great deal of guidance and training on those issues.

Q. 7.12 to 7.14. You say that within the care context, there is a general lack of understanding about adolescent sexual development and normative sexual behaviour, and that can result in children in care being regarded as "sexually deviant" for behaviour that would otherwise be regarded as normal, as we have just described. Is the solution more training?

A. I think so, yes; more training on the evidence around what constitutes normal and inappropriate and harmful

sexual behaviours. We now have some tools to try and help and support workers with this task, so these are relatively recently adopted. So the idea of a continuum of sexual behaviours that I have proposed is one of those tools, but there is another tool called the Brook Traffic Light Tool that tries to help professionals and other people distinguish between levels of behaviour. These are important steps forward, I think, that help to provide at least some guidance for professionals.

Q. Page 58, please, paragraph 7.25 at the bottom of the page. There you say that existing evidence suggests about half of sexual abuse cases in residential care refer to abuse between children. But you go on to say:

"This figure may be an underrepresentation of the true scale of the problem, given the high likelihood that peer sexual abuse in care has been downplayed by professionals who have seen it as an exploratory adolescent sexual behaviour."

Do you have any sense of what the true scale is?

A. I think I'd be guessing about the true scale. Obviously, if a quarter to a third of all sexual abuse reported across contexts relates to children and young people, and at least half of all abuse within care relates to young people, then obviously that's an elevated level. But in terms of accurate prevalence or

incidence figures, I think it would be very difficult -- unwise of me to speculate.

Q. Page 59, please, paragraph 7.26. There you note that few studies have examined sexual abuse between children in foster care. Do you know why that is?

A. There have not been that many studies, and not many recent studies, about the prevalence of sexual abuse within residential care let alone foster care. So I think it is part of this under-researched area.

Q. 7.29 on the same page. There you discuss research into the nature of sexual behaviour between peers in care, highlighting that institutional culture is one of the main factors influencing the expression of sexual and harmful sexual behaviour in care settings. You note a recent description of this as "the rotten basket approach rather than the rotten apple approach".

What does the research suggest that risks are for children in care, in terms of their sexual development and potentially developing harmful sexual behaviour?

A. I think this is an important distinction, this rotten apple and rotten basket approach, in terms of trying to move away understandings from just blaming individual children for being bad in relation to their sexual behaviour to more understanding the context in which that behaviour is expressed, and certainly in care

settings we know that children in care settings are much more vulnerable to child sexual exploitation, being made vulnerable to other adults and children around them, and makes it harder for them to achieve levels of achievement in educational contexts, et cetera.

Also, if you're a young person in the care system, the opportunities for you to develop normal intimate peer sexual relationships are obviously constrained within the setting in which you're residing. So I think there are a number of risks that are inherently part of being moved out of home care into out-of-home care that make it more difficult for children to navigate the challenges associated with sexual development through adolescence.

Q. Page 60, please. There at paragraph 7.30 you refer to a 2002 study which highlighted how macho care cultures affected not only members of staff related to girls and boys in care -- sorry, how they related to boys and girls in care, but also how young people related to one another. You say:

"Sexist and homophobic 'jokes' among colleagues created an environment in which it was difficult to detect, name and tackle abuse."

Does that mean that in such cultures, from your research, harmful sexual behaviour is more likely to

occur and less likely to be detected or tackled properly?

A. I think these cultural aspects provide in some ways the foundations upon which harmful sexual behaviour can breed within peer group contexts.

Q. Paragraph 7.34, please, page 61. There you note a study from Christine Barter in 1997 which concluded that childcare social workers and residential social workers usually denied or ignored peer sexual abuse in care or don't know how to deal with it. At page 62, paragraph 7.37 to 7.38, you refer to studies regarding the placement of children who are victims and perpetrators of sexual abuse together, and that the recommendations of the 1997 Utting Report were not followed. Has this position now changed?

A. This was 2014 research that claimed there's still problems from the 1990s in relation to victims and perpetrators being placed together. I think placement providers are now much more sensitised to the dynamics of the peer group in which they are working and accommodating. I think now there is much more awareness of the need to look very carefully at risks presented by young people on placement.

But of course, the issue for many agencies and local authorities is about where to place young people and the

availability and quality of placements, which sometimes mean, you know, they're really stuck in terms of how best to provide a good living context for young people, as we talked about earlier.

Q. From listening to you, it seems that the change in understanding a placement is a very recent one?

A. Certainly over the last ten years, I've noticed that placement providers are much more sensitised towards those issues than they had been previously.

Q. Page 63, please, paragraph 7.40. You refer to four elements of policy suggested by Farmer and Pollock in 2003 as to what could help prevent sexual abuse in care. Do you endorse those suggestions 15 years on?

A. Absolutely. I think those are really clear sets of recommendations. They are also borne out by a recent doctoral study that a colleague, Gemma McKibbin, has undertaken that has asked children and young people with harmful sexual behaviours for their own recommendations about how their behaviours could have been stopped. One of the things that -- well, two of the things that they said within this study echo Farmer and Pollock's findings 15 years ago. One is they need better sex education and help with managing their use of pornography, and the second was they needed their care placements to be safe for them in order to help them

develop appropriately without expression of harmful sexual behaviour. So I would absolutely endorse those four points and I think they are also backed up by more recent evidence.

Q. Page 65, please, paragraph 7.45 at the top of the page. There you note that consensual sexual relationships within care homes are likely in practice to result in one young person moving placements to enable the relationship to continue safely outside the confines of the home. You say the understanding of the consent is clearly a key concept. What additional measures could help to inform caregivers' understanding of consent?

A. I know this is an additional measure, but actually talking to children and young people about these issues and understanding the realities of their own attempts to seek consent and how they form relationships, particularly in the somewhat restricted environment of a care context, would be important, I think.

Q. At page 66, picking up on the earlier continuum model, you set out a model of care settings and harmful sexual behaviour ranging from healthy, to inappropriate, to problematic, to abusive to violent. We see that running across the page. Under the heading "Abusive" the third bullet point notes -- so looking at the fourth along:

"Policies and procedures which govern the care

context insufficiently guide the response required to address the issues."

What more could or should be done about that?

A. I think, in a sense, some of what I've put within this rather speculative model, I should say, that I developed for the inquiry of healthy care contexts might actually be the response to that particular point. So care is taking an active and consistent approach to being guardians, feeling equipped and empowered to support children in the care context, particularly around sexual behaviour and sexual development, strong structures, clear roles and responsibilities that support healthy interpersonal relationships in care systems. Those kinds of things I think would be my ideal care context that would perhaps address some of these issues.

Q. Can we go back, then, please, to part 4 of your report. It starts at page 20, but I want us to look at 4.28, which is at page 28. This is the section where you are looking at the evolution of the criminal justice and child welfare response to issues of sexual offence against children. At paragraph 4.28 you refer to a 2013 joint inspection report which found little evidence of proactive monitoring of the effectiveness of multi-agency work on harmful sexual behaviour. Do you think there was a failure across all agencies or

a particular agency?

A. The key aspect of this inspection report was that it was a joint inspection report. I think one of the things that they found was that there were problems in the multi-agency response, so information sharing and practice across agencies, so I think this finding relates to multi-agencies rather than one single agency.

Q. Professor Hackett, is current practice that children alleged to have sexually offended are all treated as victims as well as alleged perpetrators? Is that your understanding of current practice?

A. They're not all treated as victims, but I think all responsible intervention providers should be alert to the possibility of abuse or trauma in that child's background, and that any intervention response now is not just focused on offence-specific work but more holistic -- or should be more holistic, that actually looks at that child's individual circumstances, including their family and early life experiences, as well as their current functioning and their future goals. In other words, we have moved beyond a situation where the sponsor should just be focused on harmful sexual behaviour, particularly if we think that's a symptom of other aspects of their development and life experience. We should be not just treating the symptom,

but we should be actually looking at the causes, and I think that's now the prevailing approach.

Q. What steps do you think should be taken to avoid the risk of those who are exposed to the criminal justice system as a consequence of harmful sexual behaviour being actually harmed by that process?

A. I think there's a broader discussion to have about the appropriateness of legislative and policy frameworks derived on for adult sex offenders, such as things like sex offender registration, because we know that labelling children who are developmentally not fully formed as sex offenders and the life consequences of being labelled as sex offenders through some of these legislative policies and frameworks means that actually we are making it less likely that they can live offence-free lives, particularly when we consider the evidence that we have talked about, in terms of the low rate of recidivism for these children and young people. I think we really need to rethink our philosophical and policy-related approach to this group of children and young people. So it is right we take seriously their harmful sexual behaviour, we protect and we offer support to victims, but also we need to be mindful that these are, first and foremost, children, not just offenders.

Q. Do you think that Child Protection and Youth Justice responses to harmful sexual behaviour are well aligned?

A. They can be well aligned. I think elsewhere in the report I have talked about how the joint procedures that are often embedded through the AIM philosophy helpfully brings together Youth Justice and Child Welfare agencies in joint assessments and decision making, but I think the multi-agency inspection that we have just talked about, some of the evidence from the review by Smith and colleagues about recent practice paints a rather mixed picture on whether this is consistent across the UK. Hence the need for a topdown, overarching strategy that actually brings together some of these principles in an overarching national framework, I think.

Q. Page 77 of your report, please, section 9. Section 9 deals with the key elements of how professionals should address concerns or allegations of sexual abuse of children in care by other children. To summarise, your view, Professor Hackett, is that all staff in the care system, including residential and foster carers, should be trained and, at the very minimum, should base their responses on the principles and approaches set out in local procedures. You say that carers should not be involved in investigating or questioning the children, but should pass information on and then be involved in

multi-agency meetings and assessment of risk. You note at page 80, paragraph 9.13, please, that in your 2014 research, you were told frequently by foster carers that they were not given important information about allegations faced by children in their care or the risks associated with their behaviour. In your view, does that impede the foster carers' ability to identify or respond to harmful sexual behaviour?

A. Absolutely. How can they deal with and manage appropriately risks if they are not informed about the nature of those risks? I have to say that one of the things that foster carers told us was that they felt that they had not been given this information by professionals in some instances because the professionals assumed that they wouldn't agree to care for or look after young people if they were to find out the true picture. But of course this is really unsafe child protection practice.

Q. From your understanding, are you aware of whether foster carers are in general given greater information now?

A. This was a relatively recent publication echoing nine years' worth of practice. I think it would now be very poor -- established very poor practice not to give foster carers this kind of information, but I can't say with any absolute confidence that this is always the

case in current practice.

Q. Page 81, paragraph 9.17. You think that children, both victims and perpetrators, need someone who can help them navigate and understand the system, because many say they don't understand.

We go to section 10, please, starting at page 83. You address how professionals have addressed concerns and allegations in relation to children in care in practice. You say that before the late 1980s, good carers and professionals may not have understood the issue of sexual abuse between children, but should still have been concerned about general welfare, sexual well-being and the sexual behaviour of children and young people in care. At paragraph 10.7, please, page 84, you say while the focus has been on failure to respond to harmful sexual behaviour appropriately, there are likely many instances of good practice in spite of lack of guidance.

Professor Hackett, do you think the problem would have been one of inconsistent practice in that case?

A. Absolutely, yes, yes.

Q. Finally, at section 8 of your report, this starts at page 67, section 8 deals with the impact of harmful sexual behaviours on victims and challenges that children face in disclosing sexual abuse by another

child. Paragraphs 8.17 to 8.18, you set out some of the significant impediments to disclosure, starting at page 71, please.

Is your understanding that a child is more likely to disclose being a victim of harmful sexual behaviour than being a victim of abuse by an adult?

A. More likely to disclose? No, that's not my understanding at all. I mean, in fact, as awareness on the issue of harmful sexual behaviour perpetrated by children and young people is a relatively new phenomenon that's acknowledged and recognised, I think that it's probably the other way, it's probably less likely that children will feel confident in disclosing this form of abuse as opposed to adult-perpetrated abuse. For example, many of the public education campaigns that have existed over the last two decades that have supported children in making disclosures typically have talked only about risk from adult perpetrators. So, again, it's given some degree of education to children about their bodies and about appropriate responses to that and how they can get help if they feel that things are going wrong for them and someone is harming them, but actually if the examples given to them are only about adults, that perhaps inhibits children's ability to speak about harmful sexual behaviour by other

children and young people.

Q. Do you think there are greater barriers to disclosure in the care setting than in the domestic setting of harmful sexual behaviour?

A. I have talked in my report about how the care system is perhaps structurally weak in relation to providing some of the significant learning and evidence from studies that have talked about, you know, how children disclose, which are around, you know -- talk about, for instance, their likelihood to disclose to trusted adult parent figures, which is probably more difficult for children in the looked-after system or the care system, to have those kinds of consistent supports from their parents if they are disconnected from them. Also, there is learning that adolescents are more likely to disclose to their own peers. But of course, in a care setting, if the peers are those who are instrumental in harming them, then that further shuts down an avenue for personal support to them.

So I think we would be wise to look about how we can build and address those structural weaknesses by offering other opportunities for children, other supports for children, to disclose.

Q. I suspect I know your answer to this, but just to be clear, do you have any understanding as to whether the

barriers to disclosure of harmful sexual behaviour have reduced in the last few decades?

A. I think the broader awareness that children and young people now have about the existence of sexual abuse has been helpful in setting a context in which they are more likely to be able to understand their experiences of abuse, but of course I refer back to what I said a few moments ago about how that may be less significant in relation to this particular issue. So I think we have a job of work to do in terms of educating children more generally about this particular issue.

Q. Is there any research that you know of as to whether a child who has been sexually abused by a peer is more likely to be sexually abused by other children within the same placement?

A. I think there is evidence and understanding now that in group -- that's also been endorsed by the Australian Royal Commission recent report, that children who are abused by peers are more likely to be abused in peer group contexts rather than a one-to-one context, as is more prevalent in relation to adult-perpetrated sexual abuse. So I think that this highlights the importance of looking at peer group contacts -- sorry, I forgot your question as I'm halfway through my answer.

Q. It is whether children who have been abused by a peer in

a care setting are then more likely to be abused by others?

A. I think if we take into account that point about peer group context, then obviously one experience of harm and sexual harm within a peer group context may then predispose a kind of chain effect, particularly if there are group dynamics. So yes.

Q. Is there any research on whether that child who is abused by peers is then more likely to be abused by a carer in a setting?

A. I think there is some evidence from other inquiries that adult perpetrators of sexual abuse are able to and can very quickly prey upon vulnerable children, particularly those who have themselves been engaging in harmful sexual behaviour towards other children, as a way of silencing them. So I think that some adult perpetrators are very able to pick out those vulnerabilities and use the dynamics of sexual behaviour between children as a way of actually coercing that child into further abuse and maybe then silencing them.

Q. Again, research going on a slightly -- on a variation, an unhappy variation of that theme, so a child exposed to abuse by a carer in a care setting, is that same child more likely to be exposed to abuse by his or her peers?

A. I think if one of the consequences of being exposed to sexual abuse is traumatic sexualisation, as Finkelhor and colleagues have said, is a key impact area, then, yes, within that, that may make it more likely for that child in a care context to replicate the dynamics of what their experience has been in relation to adults with peers around them.

Q. Finally, Professor Hackett, pages 74 to 75. You set out some of the key ways in which you think adults can enable children in care to disclose abuse. At paragraph 8.25, you discuss the need to invite children to talk about their experiences on the basis that they are not very likely to spontaneously disclose. How can this be done without risking leading a child into disclosure?

A. I think if there's a culture within a care setting of talking to children about issues that affect their lives, and sensitive and personal issues, if there's a system that includes discussion around experiences of sex, that perhaps then provides a framework that gives permission for children to talk about sexual matters, including harmful sexual behaviours and experiences of abuse. In other words, setting that broader context may not then be leading a child into a disclosure, but just giving permission that, actually, the sexual aspect of

their lives is something that is of importance and would fall within the boundaries and remits of professionals in their guidance of young people.

Q. Do you think staff, care staff and foster carers, are sufficiently well trained and versed in that as at today?

A. I think we probably could do more to help professionals across the board to develop approaches and a language that would enable that. Many professionals, as indeed many parents, are embarrassed to talk to children and young people about sex.

MR SADD: Professor Hackett, thank you so much for your time. It may be that the panel have questions. Chair, I am very conscious that I have gone beyond the time, but I was very reluctant to break this evidence.

THE CHAIR: No. Thank you, Professor Hackett, we don't have any questions. Thank you for your very comprehensive presentation to us.

A. Thank you.

(The witness withdrew)

MR SADD: Chair, shall we come back at 11.35 am?

THE CHAIR: Yes, thank you.

(11.18 am)

(A short break)

(11.41 am)

Submissions by MR SADD

MR SADD: Chair, I wonder if I might ask the witness to sit down for a moment, because there are one or two observations I want to make to you and the panel, if I may.

Chair, there are two things that I wish to address you on, and one is of general note and one is of specific note. The general note is in relation to the series of corporate witnesses that we are going to hear from hereon in. It is important for me to state that some documents have been provided over the last day or two, and they arise from rule 10 questions from core participants. Chair, it is just to say this: if the witness hasn't had an opportunity to consider those documents in full, they can follow up in writing their response to those documents.

The specific issue is in relation to one particular statement that has been disclosed very recently, as recently as yesterday, and it is in relation to a third statement provided by this witness that the inquiry is about to hear from, Alison Michalska, and the fact that it's a statement of some length and deals with very specific issues in relation to issues that have come up through the course of the inquiry.

The inquiry's view is that responding to that

statement can be done in writing if there are submissions that need to be made to that statement. That can be done in writing and provided to the inquiry.

Chair, that's all I want to say on that matter. I know that when questions come to be asked of this witness, I think both Ms Gallagher and Mr Simblet will want to say one or two words about that at the time that they ask questions.

I'm told that the timing should be at this stage, so I know Ms Gallagher wants to simply have on record an issue for you.

THE CHAIR: Ms Gallagher?

Submissions by MS GALLAGHER

MS GALLAGHER: Thank you, chair and panel. We are very conscious of the time pressures today, so I will be brief. We of course can respond to the statement in writing, but I need to put on record, it was circulated to us, the core participants, at 10.37 this morning, during the course of the first witness's evidence. I wasn't using my laptop at the time. I got to see that there was a statement during the very short break. It has caused real distress and panic, frankly, amongst many of the victims and survivors, receiving it in this way at this time.

From a very brief look -- I haven't yet had a chance

to look at it in detail -- I can see much of it relates specifically to one of my clients, D6, who is here and who is presumably now going to hear a fulsome apology in relation to matters set out in this document which his lawyers haven't got to read and he hasn't got to read. We are conscious we get to put brief questions to the witness later, but, as you know, under rule 10, the format is they are very fixed, we don't get to ask follow-up questions. We cannot deal with this material. I need to put on record there is great dissatisfaction at this eleventh-hour, hurtful and shoddy approach to giving witness evidence. These are not topics which have just emerged in the last few days. Much of this relates to matters which arose in week 1. There is no excuse for it. I am asked by my clients to put on record we are extremely unhappy with this approach by the city council.

THE CHAIR: Mr Simblet?

Submissions by MR SIMBLET

MR SIMBLET: Madam, we are in exactly the same position. In fact, there are three people whom we represent that specific things relate to in this statement. Some of them purport to be some sort of apology to them. It is hardly much of an apology if they are not even aware it is going to be said, let alone be given the opportunity

to be here or to watch it or to take themselves off from their work, which directly affects one, and one of our clients does not even know that this is to be said because it came around this morning. It is not how an inquiry of this sort should be conducted and it is not how an institution such as Nottingham City Council should conduct itself.

THE CHAIR: Mr Ford?

Submissions by MR FORD

MR FORD: Chair, the statement was lodged with the inquiry yesterday morning. Its purpose is to give core participants some notice of the evidence that the witness will give. We are sorry it's late, but it does arise largely out of material that we were only told this witness would be asked about within the very recent past. It's better, we submit, for them to have that witness statement than to not have it, but we are sorry it wasn't disclosed yesterday. Thank you.

THE CHAIR: Thank you, Mr Ford. I fully understand the positions articulated by Ms Gallagher and Mr Simblet and this is indeed a very unsatisfactory position, and any outstanding matters will need to be dealt with in writing. Thank you for your comments.

MR SADD: Chair, you are now going to hear evidence from Alison Michalska. Her statement is at NCC003691.

MS ALISON MICHALSKA (sworn)
Examination by MR SADD

MR SADD: Ms Michalska, you have provided three statements to the inquiry. The first statement, dated 20 July 2018, runs to 105 pages, and that is, as I have just given the reference, NCC003691. The second statement you have provided to the inquiry is three pages and is dated 11 October 2018 and that's NCC003802. The third statement, NCC003807, runs to 12 pages, and it's dated 24 October 2018. Each of those statements I think you have signed. Is that right?

A. That's right, yes.

Q. At the time of signing these statements, were you satisfied that what was set out there was the truth, as far as you can remember?

A. That's right, yes.

Q. Do you have any corrections that you want to make to any of those statements?

A. There are two minor corrections to the first statement. The first is on page 89 in 7.85. There is a number in there of 35. That's incorrect. It should be 38. On page 104, under the heading "Quality assurance", there's a comment saying "historical quality assurance which were our briefing notes". That shouldn't be there.

Q. I don't propose, Ms Michalska, to go through your

statements line by line. I'm going to explore with you certain topics to which you have been alerted. I may have to move from one topic quite swiftly to another, bearing in mind that, at the end of my questions, two of the core participants' representatives are also going to be asking you questions. You are presently corporate director for children and adult services, Nottingham City Council, and you have been since 2013?

A. That's right.

Q. Before that, you have held various posts in Social Services, one of which at one point was with Nottinghamshire; is that right?

A. Yes.

Q. What was that post?

A. I was an assistant director for adult services between 2000 and 2003.

Q. We are first going to look at the approach to contemporaneous allegations. I want to explore a couple of matters. Can we turn, please, to page 36 of your first statement.

Under "Current position". Do you have that?

A. Yes.

Q. At 3.136 you set out details of how and on what basis issues concerning child sexual abuse would be escalated. If we move forward two pages, at paragraph 3.139 -- do

you have that?

A. I do, yes.

Q. You state that serious incidents involving children in the community or in care are escalated using an internal process that is known as "notifiable incident process"?

A. Yes.

Q. In what circumstances, please, would a notifiable incident, including allegations of sexual abuse, be reported to you?

A. So any allegations that would be around sexual abuse that involved child-on-child abuse of children in our care or where the allegation was that somebody in a position of trust had abused the child, so be that a teacher in one of our schools, a worker in one of our, say, children's homes or a foster carer. So anyone around a position of trust.

What it wouldn't do, to be clear, is notify me of allegations of abuse that were familial abuse, unless they were so extreme that it was felt that I needed to know the case details.

Q. What is the threshold, Ms Michalska, of severity for escalating an incident to the city's chief executive?

A. The chief executive would get these pretty much the same instances as I would, to be honest. So something involving a member of staff, something involving

a public figure, somebody who would be likely to be known to him, something involving a person employed by the city council. Indeed, that would be employed wider than Children's Services.

Q. So he would be told in parallel with you?

A. He would, yes.

Q. Once an allegation is reported to you, Ms Michalska, would you expect to be kept informed of the outcome of any strategy meetings?

A. Absolutely, yes, so the notifiable form -- there's an original one that he's done and then actually there are then updates sent when there's either been a strategy meeting or something of significance and it's recirculated around, so yes, I am kept --

Q. Are you satisfied that this happens in practice?

A. Yes, I am.

Q. What makes you satisfied that it does?

A. By the fact that actually notifiable incidents come to me. I will discuss them in my one-to-one meetings with Helen Blackman, who you have heard before, or Nick Lee, who is my director in education, science and services, because clearly some are originated in that part of my service. So, yes, I'm as confident as any director could be that I am kept appropriately informed.

Q. You state at paragraph 3.141, please, that there is

a requirement that members of staff who become aware of an allegation of abuse against someone working with children must report it to the local authority designated officer as well as their line manager.

A. Yes.

Q. Is there any direct liaison between you personally and the LADO in that process?

A. No. We are based all in the same office, it is a big open-plan office. I do have conversations with the LADO. They will come and find me if they are particularly concerned. But that would typically come through the management chain of the organisation.

Q. Page 39, please, paragraph 3.143. You said that in addition to the internal systems which you have described, there are two external systems used to report high-profile issues.

A. Yes.

Q. In that paragraph, you also state that the Children's Homes Regulations require the registered manager to notify Ofsted. In the last paragraph at the bottom of page 39, you state that the council don't keep a central record of these notifications, which I think refers to the Ofsted notifications?

A. That's right.

Q. But that in sexual abuse cases, there would be

a detailed record on the child's file?

A. Yes.

Q. Have I understood that correctly?

A. That is right, but, actually, from preparing for the inquiry and since this was written, two things are happening. We are having a review of our internal notifiable incidents, not least because, because of the Children's Homes Regulations, it's called a notifiable to Ofsted, there are sometimes confusions, so we are actually looking to change our internal process and not least to give it a different title so there isn't those confusions, and also I have asked that we do keep a central record of those notifiable incidents going to Ofsted.

Q. So to date, in the absence of any central record, how has compliance with Ofsted notifications been monitored?

A. It's monitored through the service manager and the head of service responsible for that service, and, again, it's something that we are very confident does happen.

Q. Monitored in what way?

A. So all the notifiable reports are signed off by the service manager responsible for our residential services, and then they are then reported through under Ms Blackman's line management.

Q. Are there circumstances, Ms Michalska, where the

reporting duty is triggered but where Child Protection Conferences are not convened?

A. So I think we need to be clear. Where there are children that are in our care and they will be subject to a care order and a care plan, so we wouldn't normally do a section 47 or child protection because the statutory requirements would be that actually that single plan would be reviewed and refreshed. But absolutely there would be strategy meetings and there will be -- you know, the incidents will be very seriously looked into.

Q. Should the inquiry assume that all such incidents are provided or have a separate record?

A. They will be recorded on the child's file. So we are very clear that actually -- this has been some of the challenges of finding, at times, types of incidents that are not necessarily recorded separately. It's really important that the records are kept on the child's file, so we have a single record about the child.

Q. But the inquiry's understanding on the basis of your evidence this morning is that, to date, and until what you have just told the inquiry, there is no central record of how many allegations of sexual abuse of children in care have occurred?

A. Yes, that's correct, yes.

Q. I want to turn next to look with you at two contemporaneous cases, those of L43 and of D6. You have provided a third witness statement in which you discuss the issues relating to these cases to some extent. In relation to L43, as you will be aware, L43, or NO-A103, was placed at Beechwood in 2002 --

A. Yes.

Q. -- and was in the care of the city council. Whilst at Beechwood, L43 was subjected to sexual abuse by another resident. The assaults were reported to the police, but the other resident remained at the home in the immediate aftermath.

A. That's right.

Q. Do you accept that this was contrary to advised practice and policy at the time?

A. Well, obviously I wasn't around, so I'm relying on the records and obviously the testaments of people who were around at the time.

Q. But you will have been advised, Ms Michalska -- sorry to interrupt you. You no doubt are au fait with the policies that were in existence at the time?

A. Yes.

Q. And you have no doubt had the opportunity to compare those policies with the actions taken at the time?

A. Yes.
Q. Do you agree that this was contrary to advised practice and policy at the time?
A. I do, yes. Yes, I absolutely agree, yes.
Q. At a 2002 strategy meeting which took place following the incident, which you have behind tab 27 of your bundle, but we don't need to go to it, it was noted that L43 "was regularly targeted" by other residents as a result of his "provocative behaviour". What more do you think the city council could, and should, have done to protect L43?
A. I think that, in any case like this, our preference would always be to try and move the perpetrators of abuse and, you know, people who have been -- children in our care will have typically been subject to certainly abuse or very difficult and challenging circumstances as to why they came into care. That does also include, therefore, those children that go on to harm others when they are in care. They are also damaged and disturbed individuals and we need to ensure that we meet their needs as well. But our preference, if we are going to move any child, if we cannot keep those children safely together, our preference would be to move the child who was the perpetrator and to try and keep as much stability for the victim as possible.

There may be times that the victim actually would be the one who wanted to move, and most importantly now we clearly listen to the child in terms of what their wishes would be.
Q. As you know, L43 alleges that he was pressurised by NO-F1 to drop his criminal complaint.
A. Yes.
Q. He was threatened that if he continued with the complaint, he would be moved to a children's home far away from his family. You say at paragraph 2.1 of your third statement that NO-F1 was dismissed for reasons unconnected with this issue by the city council in May 2011. I am asked to ask you, do you consider that there were missed opportunities in the council's handling of allegations against NO-F1, given that he was not dismissed until 2011?
A. Absolutely. What I don't know is whether -- what has been emerged about him putting wholly and utterly dreadful pressure on L43 not to press charges was just absolutely devastating. If that had been known at the time, then clearly, if that were happening now, that individual member of staff would be removed immediately. That was outrageous.
Q. I want to look, please, at the case of D6. D6's evidence to the inquiry is at tab 34 of your bundle. As

you know, D6 was placed in foster care in the mid 2000s.
A. Yes.
Q. Whilst D6 remained in the care of the city council, initially his foster family were living in Yorkshire before moving to the Isle of Wight?
A. Mmm.
Q. You discuss various issues arising from D6's case at paragraph 3 of your third statement. I want to pick up on one issue. D6 addressed in his evidence the nature of care meetings with Social Services. He said:
"The current setup with foster placement involves a lot of people, so the child has a social worker, you have the carers, those carers have a social worker, you have two line managers, a reviewing officer, a representative from the school, and often the meetings were conducted in such a way that you had to be present but you're talked around. You're not recognised as a sentient being. Decisions are made for you without -- usually without including you in the process".
Ms Michalska, have any steps been taken to ensure that the experience of children attending care meetings today doesn't match that of D6?
A. Absolutely, yes. There are huge improvements and that will be, I'm sure, of no comfort to D6. I absolutely -- I would want to offer my heartfelt and sincere apologies

too. The care that he received, in so many ways, was just truly shocking and dreadful. But now absolutely we ensure that young people -- there's a range of tools, including we use MOMO, which is an app, Mind of my Own; the independent reviewing officer will take the time to talk to the child alone beforehand to try and get their views. Young people are of course invited to be an absolute central part of their review. Some choose not to be and therefore we make sure that their views are heard through their social worker, through the independent reviewing officer or through an independent advocate, however they would choose.
We also -- one of the other things that's made a big difference is we ensure that minutes are written in such a way that absolutely the child is the centre of that and they're written in a child-friendly way, appropriate to the age of the young person. So, you know, I'm pleased to say it is very, very different. That doesn't in any way detract from how poor it was in the past.
Q. At paragraph 3.2 of that third statement, you describe the fact that there were periods when D6 was not visited as often as he should have been, and indeed he gave evidence to that effect. You say that there were points at which there were "significant staffing challenges" which impacted on the frequency of his visits he

received. You say, "I highlight this to explain, not excuse, our approach. It quite simply should not have happened".

Ms Michalska, are there measures now in place to ensure that the care of children is not compromised in the case of staffing challenges?

A. Absolutely, yes.

Q. What are those measures?

A. Well, there's a whole range of things, and probably time doesn't allow me to go into all of them. I think the most important thing has been our approach to the recruitment and retention of social workers, so the position that at the time when there were many staff shortages, and in more recent history we have had -- we have relied heavily on agency staff. I'm really pleased to say that our recruitment and retention of social workers has been very successful. We now have some of the lowest turnover of social workers in the country and our reliance on agency workers has reduced from 21 per cent down to 8 per cent. So we have a far more stable and consistent workforce.

Another really significant change is that following the inspection in 2014, we commissioned a different and much, much better IT system to support our social workers and our practice. One of the things that we

commissioned bespoke to this Liquidlogic recording system is actually for independent reviewing officers to actually record their interaction with children in between reviews to ensure that their reviews are seen, but also one of the very important things that it does is, it captures every visit that a social worker makes to a child. It captures whether the child is seen alone. It captures the frequency of those visits. It captures whether reviews and visits are held within schedule and on time. And we consider that the statutory requirements for visiting children in compare is a minimum that we will adhere to and, in fact, we actually -- many of our children are visited far more frequently and far more in line with their wishes as to when they would want to be visited and how they would want that to happen.

Q. So is your evidence to the inquiry that, as at today's date, you are satisfied that the city council social workers are visiting children in foster placements on a regular and frequent basis?

A. I am, yes.

Q. I want to turn next, please, to the city's approach to dealing with non-recent allegations. On Tuesday of this week, the inquiry heard from witnesses about the county's historical abuse team?

A. Yes.

Q. We heard that this assists with accessing childcare records relating to complainants, helps with producing chronologies to assist police investigations, produces reports for strategy meetings and offers support to complainants. Is it right that the city has no equivalent to the county's historic abuse team?

A. It's right we don't have a historical abuse team --

Q. Why is that?

A. My personal view is that actually the historical abuse team is not the right approach, and I'd like, if I have time, please, to explain very briefly why that is. First and foremost, in terms of the police accessing the records, the city council's approach in conjunction with the police is that the police come in and have full access to our childcare records. Because I do not think it is appropriate that the social worker sifts through the file and decides what is or isn't relevant to a police investigation. That, for me, and I think in law, is actually a matter for the investigating officer. So Nottinghamshire Police have their access to all of the records that we would have about a child, be that a current case or an historical case, and they come and access our files.

Secondly -- and I realise that this is a different

position for myself than it is for my colleague, Mr Pettigrew, in the county council -- is that I am also responsible for adult services and I genuinely believe that support to victims of non-recent abuse who are then by their very nature adults need the advice and support from skilled adult social workers and adult specialists. I'm responsible for adult specialists. There's been reference made by survivors very positively to Helen Jones, who is the director of adult services, who worked for me, who has recently moved on to Derbyshire. It is really important that Helen and her team are supporting adult victims. They are very aware and their social workers and mental health workers work with colleagues across health and other mental health services who are specialists in dealing with adults who were a victim of sexual and harmful abuse as children. They are the right people. I do not believe that children's social workers are the right people to be supporting adults.

What we have importantly in terms of when the allegations, be it through a civil claim route or whatever route an allegation would come to us, they are directed to a single point of access within our children and families direct services, which is where our MASH sits and our front door and single point of access into

a whole host of services.

That was why -- again, this was picked up yesterday by Ms Coupland -- when I was asked by a person to give some help and support to her son who had been a victim of abuse as a child, I put her in touch with that single point of access, because that is the gateway in, not just to the city council's services, but to health services, to adult services, to children's services.

Q. Listening to your response, should the inquiry understand that you have taken a lead on this?

A. Absolutely. 100 per cent.

Q. So you are directly involved?

A. Directly involved.

Q. How often do you review to see or evaluate how successful the approach you are taking is?

A. It really is a point of constant review, to be perfectly honest. So my colleague who works for me, a gentleman called Will Hose, he has been that single point of access. He and I -- to be honest, we see each other on a daily basis. He sits just at the other end of an open-plan office to me. He will come and talk to me if he has any concerns. But the performance reporting around that comes through our monthly reporting board but it also reports into the strategic management group that I established when I joined the city council which

oversees the work of Operation Equinox. So not just from a city council point of view, but the city, the county, the police and our health colleagues all working together.

Q. A number of survivors, Ms Michalska, have described how they have received letters from the Nottingham City Safeguarding Children Board which had provided without context a list of allegations which had been substantiated and a list of those considered unsubstantiated by the strategy panel. L48/A51, received one such letter. The letter, which we don't need to turn up, simply set out the allegations which had been considered substantiated and those which had not, and stated in the case of the latter that insufficient corroborative evidence had been found to support the claims but this was not to say that the allegations were not believed.

Why are the strategy meetings convened without complainants being notified or invited?

A. So that is -- it essentially is a real hangover from historical allegations -- allegations of abuse management system I think it was called, sorry, the initials -- it is in that part of, I think, my statement that refers to that. That was an old system that actually is no longer a requirement, and that was very

much around just capturing, from the LADO's point of view, the relative merits of the allegations received. It's an awful letter. The author of that letter -- it is a standard letter that is filled in by the LADO. The author wishes me to pass on her apologies to the particular person and indeed anyone else who has received them --

Q. Ms Michalska, can I interrupt you? The nature of the letter to the recipient is indeed very important and has the potential, as indeed this witness describes, of affecting them.

A. Yes.

Q. At what point was any thought given to how that pro forma letter which you describe ought to be changed?

A. Being perfectly honest, no thought was given to that until this complaint. What I'm pleased to say, although it doesn't help this particular person at all, nor anybody that's received a letter in the past, but will in the future, is that we now have actually recruited somebody to put together not only just to deal with that in a very different way, but will also offer anybody who is going to receive that letter -- well, receive the information, it won't be a letter in that way, to have the opportunity for someone to come and visit them at home or for them to come in and we will go through the

findings of that.

Q. Why is it that conclusions are reached about allegations without input from the complainant about whom the meeting is conducted?

A. I can't answer that, to be honest, other than the fact that doesn't seem to be a very fulsome way of doing so. I can only assume that the LADO takes it from the presenting information, so I'm sorry that feels very unsatisfactory.

Q. L48 and other complainants have described the distress that they experienced in being informed of the board's conclusions regarding allegations without being provided with any rationale for the decision. At paragraph 4.4 of your third statement, you say:

"Moving forwards, all survivors of non-recent abuse will be offered the opportunity to meet with someone senior from the city council to discuss the outcome letter they have received, should they wish."

A. That's right.

Q. At such meetings, Ms Michalska, will complainants be provided with an explanation of the rationale for the conclusions arrived at by the board?

A. That is exactly the purpose of that meeting, and to both receive it in a way that hopefully is more conducive to what they would need, but also having a much fuller

explanation, and also an opportunity for them to ask more questions, so if they don't have sufficient evidence -- information, we can then go back to them.

Q. In the case of L48, are you in a position to explain to him why his allegations of sexual abuse were found to be unsubstantiated?

A. Sitting here personally now, no, I'm not. But I'm absolutely very happy that senior colleagues, who were involved in that investigation, would be very happy to meet with him and indeed anybody else who wants and deserves further explanation.

Q. The next case we are going to look at, please. The inquiry has heard from L43/A103 in the first week of the hearings. L43 discussed his experience of bringing a civil claim against the city council. He described how he found the offer from the council "insulting". Referring to the offer in his evidence to the inquiry, L43 stated:

"It's like offering me a £10 note and telling me to go home and shut up. That's what it is. It's disgusting."

L43's comments on the process of bringing a civil claim reflect those of many core participants whose evidence is before the inquiry. You discuss the city's approach to civil claims at paragraph 5 of your third

statement. To what extent, Ms Michalska, do insurers inform the city's approach to defending claims?

A. They don't, to be perfectly honest. I think that not just through this inquiry but since I became involved in looking at civil claims over the last -- the five years I have been working for Nottingham City, I have thought that the system is very adversarial, it's very clunky, it certainly isn't conducive, I don't think, to people feeling supported through that purpose. I think it is one of the things I would sincerely hope that either this inquiry or the reparations strand of the IICSA inquiry can seek to address. There are huge contradictions in terms of the way that people are able to access information. It is a very unwieldy and not at all friendly process for anyone to go through.

Q. Although I'm aware, Ms Michalska, that counsel for core participants will be returning to issues relating to civil litigation, I just want to ask you what sorts of considerations inform the city's decision about whether or not to defend a claim or try and settle it?

A. They are dealt with through our risk and insurance as a first point, as any civil claim would be, whatever the nature of it. They will --

Q. May I interrupt you there?

A. Sorry, yes.

Q. Just to pick up on what you have just said. You said a moment ago that the insurers do not play any part in the decision whether or not to defend --

A. Yes.

Q. -- or settle a claim. The first -- you then have just said to me that the first thing that happens is that the claim goes to the risk and insurance department?

A. I'm sorry, then I have confused the two things. I thought, when you said "do insurers", I thought you were relating to any external company who may have insured the county council against -- the city council against losses. They have no part in it. They might try and seek to influence, but I'm very clear that actually that, in terms of claims of this nature, the view of the insurers, in my view, is irrelevant. It might be relevant about a kerb -- you know, a raised kerb or something, but in terms of where we are dealing with things like historical abuse of children in our care, an insurance company, to me, has no view in that.

We have a section in the city council called our risk and insurance and they are the part of the council that deals with a whole range of risks and assessment of our risks and also deals with our insurance companies over a whole range of different issues. So I'm sorry if I wasn't clear about that.

So our risk and insurance team, who are a city council team, will look at the claim in its first instance and they will work with social care or other -- whatever other parts of the council might be involved, to try and pull together the relevant records in terms of assessing how we might progress this claim.

We always want to progress them as quickly as possible. For all sorts of reasons, often completely outside the city council's control, things take a lot longer.

Q. The inquiry has heard evidence from a number of complainants in receipt of counselling who are concerned that their counselling will be terminated. It is understood that city council co-commissions the independent sexual adviser service?

A. That's right.

Q. Is that right?

A. Yes, that is right, yes.

Q. In addition to co-commissioning the service, what other specialist counselling does the city council provide?

A. So we commission a range of other services as well, like the Imara Service, which deals again with -- specifically around sexual abuse that children suffer, be that familial abuse, peer-on-peer abuse or whilst in care, and there's a range -- a whole range of services

that we commission, and then of course in our adult services we have specialist workers employed directly by the city council and of course our children's social workers.

Q. Are you able to provide an assurance to victims and survivors in receipt of counselling from the city council that they will continue to have access to such services for so long as they require it?

A. Yes, and I think you heard Councillor David Mellen yesterday saying that, actually, children in our care and victims and people who have been in our care historically are our biggest priority, so absolutely.

But clearly, some counselling of course is better provided through the health service and we will always advocate that people receive that counselling if that is more appropriate than something we directly commission.

Q. At paragraph 10.2, please, of your third statement, you discuss the issue of support for A303's mother.

A. Yes.

Q. You describe how, following a meeting that took place on 18 September 2014, you made contact with A303's mother by email, an email which we saw yesterday.

A. Yes.

Q. And that the email provided relevant contact details for children and families direct. You have heard

Mandy Coupland's evidence on this issue. On reflection, Ms Michalska, do you think you could have done more in the wake of that meeting with A303's mother?

A. When I met A303's mother she had been at part of the meeting and then she talked to me afterwards in what was the very public foyer of our building. I agreed I would email her so she would have my email and phone number, but I would put her in touch with, as I explained earlier, the right part of the council so she could get the help and support she needed and advice on how to access that for her son.

Whilst I'm a corporate director who has that ultimate responsibility for children and adults and public health services, that doesn't mean to say that I, as an individual, am necessarily the best person to be working with an individual. My role is to ensure they receive the support that they need.

Q. At part 6 of your third statement, you deal with the Historical Concerns Project. You say at paragraph 6.1 to 6.2 that after you became corporate director of children's services, you were briefed in relation to the ongoing investigation into historical abuse. You say that you commissioned a project to "ensure that senior management were fully apprised of the potential risks presented by individuals who were or had been employed

by the city council". Have I got that right so far?

A. Absolutely, yes.

Q. Can I ask you, please, to turn to tab 16 of your bundle. This is document NCC003708. Can we have this up on screen, please? From the title, it appears this is a table of employees and ex-employees who were subject to allegations of, or concerns about, sexual abuse of children considered as part of this project.

A. That's right.

Q. What was the purpose for the creation of this spreadsheet?

A. So just wind back a little bit. When I first wanted this piece of work doing -- because what I was conscious of is that there are staff that had been taken on by the city council and previously worked for the county council, so they'd transferred to us at 1998, and that other staff would have been recruited in the time when our recruitment processes are nowhere near as robust as they are now. I was concerned as well that I'd seen evidence, particularly in relation to -- I'm trying to remember his cipher -- 01 and 02, that really concerned me. Because some of them we have touched on in this inquiry, but they were matters of a similar nature, where actually both of these had been raised in a number of civil allegations -- sorry, civil claims and

in criminal allegations, particularly around physical abuse, and I was concerned that, are there other staff still working for us, or historically had worked for us, who had now been allowed to leave under whatever circumstances, who, if they were coming to jobs for the city council today, we would not employ, and I was uncomfortable, as a new director coming in, not knowing who was in the council's workforce who might have historically been a risk to a child and had been treated differently or might currently be a risk to a child and being employed.

Q. To whom was this information distributed?

A. The detail of it, so the unredacted version of it, was distributed to myself and then my head of safeguarding, who together we -- he managed the safeguarding -- the LADO processes and the strategy meetings around the individuals with HR colleagues and other colleagues that needed to be involved. So he and I.

Q. So he took actions as a consequence of this?

A. We agreed them together, and I took the actions.

An anonymised version, like -- so a version of this that had the definitions around the risk, the totality of the number, but not the names, was shared with the corporate leadership team because it was really important that the whole council own this, because the

resultant changes to our recruitment practices affect the whole council, not just children's and adult services, but whether you are recruiting into leisure services or whatever. So it was really important that my corporate colleagues knew and understood and supported this action.

Q. Over the course of the inquiry, Ms Michalska, we have heard evidence about the issue of records and the distress that victims and survivors have experienced as a result of delays and failures to disclose records. You discuss this issue at paragraph 7 of your third statement.

You state at paragraph 7.5 that, in the light of the experience of D6, you have agreed to establish a new role dealing wholly with the provision of social care records. You say that by the time the inquiry hearing has ended, so presumably by the end of tomorrow, you will have recruited someone to the above role?

A. That's right, yes, a colleague was recruited last week, a new colleague.

Q. What do you say to Mandy Coupland's proposal that independent archivists ought to be brought in to urgently review and deal with the council's records?

A. I think we can -- I think we are slightly conflating two issues here. The issues that I fully understand

around -- that Ms Coupland was raising and indeed I have dealt with and personally met with numbers of survivors, Mr Summers probably in particular, they are talking about us being unable to find records that predate when the city council -- the city corporation was responsible for social care, so pre 1974. That was a time when -- I'm sure I'm not telling you anything you don't know -- the requirement actually was to destroy records, not to retain records.

This new -- and, therefore, it isn't about -- so I think it's right to say that we have found some old records and not others, and that, to be honest, is by chance that we have found them. So the only records we have found pre 1974 were the records we were required to retain, so things like, for example, the admissions register and some medical records. Any other personal care records have been destroyed and that is terribly sad and we have invested time and effort in working with individuals to try and help them piece that together. What this role, though, is about is to overcome the issues that D6 and others have had about access to their current records and the far more recent records and of course those records that now, as there have been changes in legislation and the Children Act, we are required to retain for much, much longer.

Our records now are almost wholly electronic -- certainly any records we are creating now are electronic records. We still have some paper records going back to pre that system and what this person will do, will make sure that people get the timely access to them, will make sure that they are redacted in a way that is appropriate, but then, importantly, will sit and talk through those records, because I believe it is wholly inappropriate that someone receives that record of their care history and information about their family in a way that is just cold and arrives through the post or however they receive it. I think people should be offered, and will be offered, the opportunity to sit down one-to-one with somebody and go through that and be supported.

Q. Does the city council currently have systems in place which allow it to comply with its obligations --

A. Absolutely.

Q. -- under the data protection legislation regarding the processing of subject access requests within the statutory timeframe?

A. Yes, it does.

Q. If so, what do you say to complainant core participants, and in particular D6, who gave evidence about seeking his records over a three-year period, who have routinely

experienced delays in obtaining records?

A. So I have written to D6 about trying to explain this, and I realise that this is something that there were mistakes, there clearly were mistakes. When the subject access request was initially received, it wasn't received by the right part of the council, and I can only wholly apologise for that. Then, when it was received, unfortunately D6 didn't provide the necessary information, because one thing we require, if somebody is asking for records, they do need to prove that they are that person, and I'm sure you can understand why that would be.

Then I think it was further confused -- this is one of the points I said about earlier, it's very confusing -- that when somebody has solicitors acting on their behalf for a civil claim, actually the information that they can receive through their solicitor in that route is actually far more extensive. Now, some of the delays around the subject access request and also I think it affected the civil claims access was that we -- that the solicitors representing D6 were hoping that other members of his family would also give permission to release their records, because on its own, you will only receive a partial story. That did take some while and, as I understand it, only one member of

the family has agreed to that. So that did contribute to the delay. But in a way we were trying to get the most fulsome records. I absolutely apologise for the delay that was caused by the city council, but these are two processes that actually inherently conflict with each other and that is something I hope the inquiry can help rule out for other people. It doesn't just affect the city council, that will affect everybody up and down the country.

Q. You describe in your statement in exhibit AM9 -- this is your first statement -- about the process of storing files, and you say that all files from Carefirst and Castle were transferred to Liquidlogic. I think that's in 2001.

A. That's right.

Q. Does this mean that all files back to at least 2001 are in electronic form?

A. Yes. So Castle and Carefirst were the original electronic system that was replaced following recommendation from Ofsted in 2014 and the new system was procured and commissioned and came into effect from November 2016 and the Carefirst and Castle records have been transferred onto that. So, yes, we now have -- as I was saying a few moments ago, our records are now wholly electronic, but there are still some

paper records that will predate that original electronic system of the early 2000s.

Q. Some of the complainant core participants have been provided with only partial records, having been told that city council employees overlooked to search for records in Liquidlogic. Is there any reason why a search of these records might have been overlooked?

A. That was -- I'm afraid it was a human error, it was a misunderstanding for somebody who previously worked for our risk and insurance that hadn't understood that we had moved over. The only records that would have been missing, though, if I can go on to say, is records that have been recorded after November 2016. So they're the only records that would be solely on Liquidlogic.

Q. In her statement to the inquiry, Mandy Coupland discusses her efforts to assist one survivor, Mickey Summers, access his records. She sets all that out. She says she was surprised that she had been able to uncover relatively easily what the city council hadn't been able to uncover themselves.

Do you have any comment, Ms Michalska, on why Ms Coupland may have been able to locate Mr Summers' records whilst the city council were unable to do so?

A. So to be very clear, and I don't want to be critical of Mr Summers, there were some records that were provided

to Mr Summers which are the only records that the city council, and indeed the county council, who actually had his records, were able to find. They were the admissions register that said when he was in certain homes on certain dates and some medical records. We disclosed those to Mr Summers via email when he was living in America. The records that then later Mr Summers put on Facebook as saying "A friend of mine has been able to find this", that I know now is Ms Coupland, were the records we sent him.

Q. I want to turn, please, to the issue of apologies. Yesterday, I took David Mellen to the minutes of a meeting of the Safeguarding Assurance Forum in February 2018. The minutes are at NCC003688, and we looked at them, or I looked at them, with Mr Mellen yesterday. The minutes note the leader's stance regarding the city council being asked to apologise?

A. Yes.

Q. The position being, "We will apologise when there is something to apologise for". Were you involved in that decision making?

A. So I want to take the opportunity, really, to put a lot more context around that statement, that quote, from the leader and the stance of the council towards an apology. The city council has always believed, and indeed we have

heard this, I think through the inquiry, that apologies should be delivered in person to the individual concerned, and I have met with individual survivors, as has the leader of the city council, the leader of the Opposition, the chief executive, and equivalent colleagues from the county council. I have met with individuals and personally apologised.

In other cases, there is the case of the foster carer that came to trial, although was not convicted, that his victims -- senior colleagues went out to support those victims, obviously to apologise to them for the abuse that they suffered, or they alleged to have suffered, and we absolutely believe them, at the hand of their foster father and adoptive father, and we apologised to those people in person. The same was true of the victims of Helen Logins. They were apologised to by a member of my senior staff and a senior police officer, who went out to visit them and to offer them support. That is our approach, whether it's the approach to people who have been harmed that have been the subject of a Serious Case Review or whatever the circumstance: we will offer an apology individually.

The leader of the council's view was more in relation to making a bigger public apology. I think the other thing I would want to say is that the

city council's website has always been clear that, had people been harmed in our care, that is truly abhorrent and we are generally and heartfelt very sorry. What the leader of the council actually said -- and, to be fair to the leader, what was said in that meeting and recorded in that meeting was a very -- was a paraphrase and actually really very -- it lost all the nuance around it. What the leader of the council would say if he were here and the conversations I have had with him at length about this is, if there is an instance where an employee or ex-employee or foster carer of the city council is convicted in court and therefore it is a matter of public record that certain people have been abused, in the way it was, for example, with Andris Logins or Dean Gathercole or Myriam Bamkin, that actually they were previous employees of a council who had been convicted, and that was very much a matter of public record, he would then, as a matter of public record, apologise, but his view, and I share his view in many ways, is that, where that is not a matter of public record, that apology should be in public -- sorry, should be in private, and that actually making public pronouncements around intensely private things that weren't in the public domain, actually, he felt, could potentially do more harm than do good. And he also

believed that they are -- they would be perceived as just a hollow, empty statement.

So I think what I want to say is that I --

Q. May I interrupt you, please?

A. Sorry, yes.

Q. Were you involved in the leader's approach to making apologies?

A. I have sat down with the leader, the deputy leader and the executive of the council and we have discussed this together.

Q. So the answer to that is yes?

A. Yes, absolutely, yes. Yes. Absolutely.

Q. Was the note that we see in February 2018 in fact considered following the county's apology in January 2018 about which we heard evidence yesterday?

A. Yes. It was a direct follow-on from that, in that actually the local media were asking the leader of the council whether he would make an apology, and that was about the public apology that I hope I've explained his view.

Q. Should one understand that, until the county had sought to make a public apology, the issue hadn't arisen in discussions that you had with the leader of the --

A. No, it had arisen right from my -- as soon as I began working at the city council and was aware of this

emerging historical abuse investigation. When I organised and set up the strategic management group, one of the things that was a work stream of that group was about communications, and not wanting -- and very much working with the police, because not wanting to prejudice any trials, but also wanting to make sure that people were aware and actually would come forward to help with evidence. But it was from the strategic management group that actually on the council's website was a very clear statement that it was -- had anybody been abused in our care, that we were deeply sorry and we would encourage them to come forward.

Q. June 2018, The Nottingham Post published an article which is in your bundle --

A. Yes.

Q. -- we don't need to see it -- in which you were reported as having said that there was no evidence which would suggest there was widespread historical abuse of children in the city's care by a large number of people.

In your supplementary statement to the inquiry, you suggest this article was not put in its proper context and all you meant to do was address a very specific allegation that there was a paedophile ring operating in residential care in Nottinghamshire. Similarly, you are reported as saying in that article:

"There is no evidence that I told X and they did nothing about it."

In your second statement, you say at paragraph 1.6 that again the article is a misrepresentation of what you said and the second half of your sentence was left off, which makes clear you were referring only to the fact that be there is no evidence of current staff failing to act. Did you contact the editor of The Post to correct that?

A. We didn't, no. We take the view, to be honest, that -- obviously I agreed to meet with The Post and have a discussion with their reporter to try and help with some context in preparation for these public hearings as well as updating them on the ongoing work that we are doing. What I was talking about, very clearly talking about, was incidents of abuse post 1998 when the city council had taken back responsibility for children's services. You have rightly said that the first bit -- I was asked a very specific question about a paedophile ring, and I think we have heard from the police that their view is that there is nothing that would substantiate there being a paedophile ring. And the second bit was, I was talking about practice now. Because what he was asking me, very sensibly, was how am I assured now about -- that if something was happening

that staff would speak up and would report it, and you've explained, it was only a part of what I said.

Q. Do you understand why, Ms Michalska, some complainants feel that the apology finally offered by Ian Curryer on 14 September 2018 and reiterated by Mr Ford QC in opening submissions is seen as both too late and not going far enough?

A. I totally accept that. We had a lot of discussion -- the reason that it was felt appropriate at that time to make that public apology goes back to what the leader of the council's view was, and whilst there was nothing -- you know, we haven't had a member of staff or a foster carer convicted, what was disclosed to us at the time that apology was made, so a few days before, were some papers that were coming to this inquiry that we hadn't seen, that I hadn't seen, previously that made it very clear that, as a city council, we were rightly going to be criticised in relation to Beechwood, and a lot of that related to the questions that you put to Mrs Mackechnie earlier in this process. I was very clear then that the city council, rightly, was going to be criticised for failure to close Beechwood in a timely way and the resultant issues that that created for a number of people.

We were very aware and had long conversations about

the fact that the timing -- we would be criticised for the timing, we would be criticised for doing it -- we also felt we would be criticised for not doing it. So actually, it was a very heartfelt, very sincere apology and it seemed appropriate to make it. What we also said at the time was we were aware we were making this apology and we fully expect, as Councillor Mellen said, that in the fullness of time, when we are clear and the inquiry has helped us with our understanding of the elements that the city council have been responsible for, that we apologise. You know, Councillor Mellen, Ms Blackman and myself here, we are so sorry for anybody that has been harmed. Care should be about being safe. You know, I cannot say how sorry we are that people are harmed.

MR SADD: Chair, I am conscious of the fact that I have about five minutes more of questioning, and there are 22 minutes of core participant questioning. In the light of that, chair, would you be prepared to sit, please, until 1.15 pm?

THE CHAIR: Yes, we will do that.

MR SADD: Thank you very much, chair.

Looking at the oversight of residential homes, please, Ms Michalska, how often does the residential service manager visit homes?

A. She's out and about in our homes daily.

Q. Are these reports of visits sent to you?

A. They're not sent directly to me, they're sent to Ms Blackman, but a digest of them comes to me and of course, if I want to see any of them, I can. And I also visit the homes myself. I would like to make that clear. I must say, she's an incredibly competent person, and somebody that Ofsted have remarked personally on her ability and use her as a very positive role model for other local authorities.

Q. Are regulation 44 visit reports sent to you?

A. The detail of them is not sent to me, no. But, again, I can access them, if I wish, and they are reported, as you know, through the proper processes.

Q. I want to look at one specific matter, please, Ms Michalska, the closure of Beechwood Children's Home. Paragraph 5.11 of your first statement. You discuss the investigation report of Bronwen Cooper?

A. Yes.

Q. The inquiry has heard evidence about the report, that the report initially contained a recommendation to close Beechwood. This was revised following a discussion with the request of Ms Mackechnie. Do you consider that the recommendation to close Beechwood in 2001 was pertinent --

A. Absolutely.

Q. -- given the escalating concerns at that time?

A. Absolutely. Beechwood should have been closed in 1998 as should all of big children's homes. Our children's homes now have two or three children within them. They are like family homes. Any big institution should have been closed a long time ago.

Q. Does it follow from that answer that all the subsequent steps taken to address issues at Beechwood were ineffectual because that home should not have been running?

A. I think they were wholly inadequate. It had a staff team that, looking back with hindsight -- I don't personally know any of the people that worked there but they appeared to me to be people who didn't have the best interests of children, and even those who did, and we have heard evidence from some people who worked there that they were trying to do their best, but I just think that the style of the building, the style of the care, the mix of children, just was awful.

Q. We have heard evidence, Ms Michalska, about personal advisers for care leavers. Last week the inquiry heard evidence from Helen Blackman who stated there is no difficulty with personal advisers for care leavers being employed by the city council. You state at

paragraph 10.3 of your third witness statement that you sought legal advice and that you support the views expressed by Ms Blackman?

A. That's right.

Q. At paragraphs 10.4 and 10.5 you discuss two cases that Ms Blackman was referred to. But notwithstanding the legal position, in practical terms, are there any situations in which you consider that difficulty may be caused by the fact that a personal adviser is employed by the city council?

A. I can see why there could be conflict. But this is one thing -- it's the same with the independent reviewing officers and personal advisers. As the law currently stands, statute says that they are to be employed by the council or commissioned by the council and that actually the role of the director of Children's Services that I have in statutory guidance it is very clear that services that are -- the social work children's services have to be line managed by a social worker from the front-line right through to the director of Children's Services. So I think that for them to be anything other than employed or commissioned by local authority would be contrary to that current piece of statute.

So there are -- there would potentially be conflicts, but in the same way as there are formal

escalation routes, one of the things that I and Ms Blackman and Councillor Mellen, as you heard, go out and visit staff, we will visit our personal advisers, I also have -- every month I have a session called "Meet the corporate director" where colleagues, front-line colleagues, come and meet with me and can talk about whatever they would want to talk about. Therefore, if somebody had a cause for concern, they know how to come to me directly, and I am confident that they would.

Q. What about the situation of children who might have a civil claim against the city council, but within the current limitation period of that claim, so still under 24 -- or under 21, I should say, would a personal adviser employed by the council be an appropriate person to assist that young person in making decisions about that?

A. I think a personal adviser, their role is to have the young person they're supporting at the heart of everything they do. If that includes bringing a claim against the council, whilst we'd need to make sure they weren't doing anything that then could in some way conflict them personally, of course I would expect them to help. But actually, what I would expect them to be doing is ensuring that they are getting proper, independent legal advice to be able to do that, because

our personal advisers, you know, they're not -- they are not lawyers.

Q. Finally, Ms Michalska, as far as my questions are concerned, the inquiry has heard evidence in relation to the county council's approach to harmful sexual behaviour in recent years and at present, including the carrying out of an audit in October 2016 using an NSPCC framework, including the formation of a Harmful Sexual Behaviour Panel in January 2018 and the carrying out of a harmful sexual behaviour audit in May 2018. What has the city council done in the last couple of years to address harmful sexual behaviour?

A. So the city council has been addressing harmful sexual behaviour for a much longer period of time than that. There have been various iterations but the current arrangement is a process called ASHA and I think you have had statements from somebody who was going to be a witness but then was stood down around this. So what the ASHA panel do, it is around the assessment of harmful sexual behaviour, and it looks at both the victims and perpetrators of sexual violence.

So in terms of the most recent statistics -- sorry, I asked for this knowing I was going to be asked. Excuse me just two seconds while I pull it out. In the last two years, in 2016, there were less than

20 children with sexually harmful behaviour presented to this panel. So we actually widened the scope at that point to look at children and young people whose behaviour could be indicative. So initially, it was just those children who had already been the victim or had actually sexually harmed other children. Whereas actually we have now said that we need to look at children whose behaviour might suggest that they would go on to do that. So, for example, children who are accessing pornography. In 2017 to 2018, 67 children were presented to the panel and to date in 2018/'19 -- so to date -- 30 children have been presented to the panel.

Some of those children actually were very young children, some as young as 6 --

Q. Ms Michalska, sorry to cut across you. I know it is information that you are providing, but in summary, would you want the inquiry to conclude that the city's present approach and policy towards harmful sexual behaviour of children in care is being properly addressed?

A. I would, but can I just say, this isn't just about children in care, this is all children. So these are children -- actually, most of the incidents of sexual harm are between siblings or children who are not in

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

MR SADD: Ms Michalska, thank you for your patience with me. You will now be asked questions by my colleague.

Examination by MS GALLAGHER

MS GALLAGHER: Good morning, Ms Michalska.

A. Good morning.

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

A. That's fine.

Q. I say that just for those who may expect me to put these questions, which I can't, for reasons you understand?

A. Yes.

Q. I'm entitled to ask you questions on three topics which have been agreed in advance, not on these issues?

A. Yes, that's absolutely fine.

Q. The first thing I want to ask you about concerns reputation management, an issue which has arisen with Mr Sadd. Could I have on screen, please, NCC003687_004. It is your AM68. I'm not sure where that is in your bundle but it should come up on screen. Do you see, down at the bottom of the page, there is the heading "Project objectives"?

A. Yes.

Q. Just to orient yourself, this concerns the Historical Concerns Project you commissioned in 2014?

A. Yes.

Q. Can we highlight the first bullet point:

"Minimise the reputational risk to the council."

Ms Michalska, a central aim of that project, indeed the first one listed here under "Project objectives" was reputation management, wasn't it?

A. Not reputation management, no. I think that's a subtle difference between reputational risk. What this was getting at was, I did not want to be the director of Children's Services who knowingly had somebody who had either been previously disciplined for harming children, or there had been issues of harm to children in their personal life, still working for me who could then go on and harm a child.

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

Q. If we go over the page to 2.3, do you see the first bullet point which says:

"Project benefits.

"Children and adults are safeguarded from potential harm."

A. Absolutely.

Q. So that was central to what you were trying to do?

A. Absolutely, and that is central to our reputation. We need to have a reputation that children are safeguarded and that adults are safeguarded, and that people can come -- can feel -- the only way that I know a child or an adult is at risk is because somebody tells the council -- be that a member of the family, somebody

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

Q. Can we go back to page 4 and have the entirety of page 4 on screen, just following on from that. So you have just told us that -- about the objective of children and adults being safeguarded from potential harm?

A. Yes.

Q. Do you see it has, "The project will address ..." and there is a long list of matters "in scope" and a long list of matters "out of scope". Can you just assist us with this specific issue? In the "out of scope" section, two bullet points from the bottom, where it says:

"Foster carer records."

If an objective of the project was to ensure that children currently in the council's care are protected properly, can you assist us with why foster carers weren't included --

A. Absolutely. Foster --

Q. -- in the scope of the review -- if I can just finish -- given that most children in the city's care are currently in foster placements?

A. Because foster carers are not our employees and, in terms of ensuring our children are safe with foster carers, it's a very different process. So to be clear,

our most vulnerable children in care, most of them are in foster care. You are absolutely right. This was about an employee's project, which is why foster carers are out of scope, because they are not our employees. But please don't interpret that that we are not bothered about foster carers, of course we are.

Q. Thank you, Ms Michalska. The second issue I want to ask you about is this: a central thrust of the evidence we have got in writing, and indeed your evidence today in relation to abuse in care, is that it's largely historic and procedures and practices in children's services are much better now than they were then. A kind of "That was then, this is now" approach.

A. But --

Q. Just hear me out. We have a very short amount of time and I have some specific questions. We are not allowed to come back when you say things back to me. We are not allowed to ask follow-up questions. So just let me get through the question.

A. Okay, fine, sure.

Q. Your evidence has largely been that this is historic and that things are now very different. But Nottingham City Council's Children's Services Department has been the subject of recent criticism, hasn't it, from -- just to give you a first example and I will ask you about this,

from Ofsted in 2017. Could we have on screen, please, OFS008274 at page 2. You will see at page 1 there -- it went past very quickly -- it referred to the need for experiences and progress of children, the third one down:

"... children looked after and care leavers, and achieving permanence: requires improvement to be good."

A. That's right, yes.

Q. Then on page 2, under "What needs to improve" -- can you see that?

A. Yes, of course. I'm very familiar with this.

Q. "Services for some children are not yet good."

A. Yes.

Q. Could you look at the third bullet point:

"The council does not always fully understand the reasons why children go missing and therefore does not always give children the help that they need."

Just before you comment on that, can I give you the last reference on that? It is on page 4 at paragraph 12, if we could highlight that. That says --

A. Yes, I'm very familiar with that.

Q. "Staff do not consistently carry out return-home interviews when children go missing, including children looked after. They therefore do not explore the reasons why children go missing, which limits their ability to

construct and implement appropriate risk management plans. Managers do not oversee return home interviews consistently or effectively enough."

This isn't historic, Ms Michalska, this is 2017. Do you accept that that's a continuing obstacle to identifying children who are subjected to abuse?

A. So two things I would say to that. Yes, that is in 2017. I think if you look at it in the context of the previous inspection, 2014, you will see that a number of the services have improved significantly.

Q. Not this, though?

A. These areas --

Q. This --

A. Please let me finish.

Q. Of course.

A. These areas are areas that in our own self-assessment we said these were areas that, as of February 2017, we were saying these areas were not yet good. Being judged as "Requires improvement" means that, actually, you meet all of those statutory minimum standards, but for us statutory minimum standards are not good enough, and these were areas that the council was in of itself self-critical and actually Ofsted agreed with us.

So I have never said -- just to go back right to originally, I've never said this is all about history

and this doesn't happen now, so I'm not sure where you have heard that from. What I have said, I think, consistently is practice is much, much better now. I say that not just as the director of Children's Services, but as the -- until last year, the president of the Association of Directors of Children's Services. That is a reflection of all of England's practice towards children. There are still things that go wrong and every time something goes wrong that is terribly, terribly sad, but generally things are much, much better.

Q. You accept this is an area where it's gone wrong recently?

A. This is an area where our practice was not yet good. What I will say in relation to both of those things, in terms of return-to-home interviews, Councillor Mellen described yesterday --

Q. Could I interrupt you for a moment? The result of a very, very long answer is that we won't get to ask all the questions we are entitled to ask.

A. Sorry.

Q. I think I have the key point, which is you accept this was a criticism in 2017?

A. It was our own criticism.

Q. And you are not suggesting that every area is perfect.

A. Of course not. I would be foolish to say so.
Q. Can I suggest, that perhaps, rather in the way we have had to, if there is further detail to add --
A. Of course.
Q. -- it can be provided --
A. Very happy.
Q. -- in writing rather than meaning we can't ask questions which are very important --
A. Very happy.
Q. -- to my 45 clients?
Can I give you another recent example from 2017 and this concerns the death of a child, Child J, and it is a Serious Case Review by the local Safeguarding Children Board. The reference is INQ002949. Again, this is another 2017 document, a document from last year, about the death of a 7-year-old girl.
Could I ask, firstly, if we go to page 38, paragraphs 3.133 and 3.134, just for speed, that simply says that Children's Services closed the case in July 2014 and the child then died in July 2014.
A. Mmm.
Q. That's a case where she'd sustained physical and emotional abuse and she died of quite horrific injuries; is that right?
A. That's right, yes.

Q. So it is not a sexual abuse case?
A. No.
Q. But the reason we are raising it is because it raises concerns.
A. And the child wasn't in care.
Q. Precisely. There are a number of matters I want to take you to that we are entitled to take you to in relation to this document. The panel will read it in full.
Firstly, can I ask that we look at page 43 of the document, paragraphs 4.14 and 4.15. It may take a moment for them to come up on screen. Here in paragraph 4.14 there is a description when the child is with her aunt and being supervised by Social Services and that the aunt reports to all professionals that Child J's behaviour was unmanageable. Do you see that?
A. Yes.
Q. That she was self-harming, stealing and increasingly she described Child J as being deliberately naughty, defiant and unremorseful. Do you see that?
A. Yes.
Q. It then says "This was not sufficiently challenged directly with aunt ..."?
A. That's right.
Q. In paragraph 4.15, the first sentence:
"Despite there being much discussion of Child J's

early experiences, the records and discussions suggest that child J started to be seen as a difficult and complex child by professionals."
Would you accept that one of the key themes from this long document is that professionals who were seeing Child J and her aunt focused on supporting the aunt and dismissed concerns about the aunt's behaviour, on the basis that the child's behaviour was difficult?
A. I think that's absolutely right. You know, we authored and contributed to a great deal of this report and, as the director of Children's Services, I have the responsibility for all the services, not necessarily directly through line managed, but the school, the health services, all of the professionals who actually were believed by the aunt rather than necessarily listening to the child.
What, again, I will put back in writing to you because of time is around the significant differences and the -- the purpose of Serious Case Reviews is always to establish what is the learning. There's been a huge amount of learning following the death of this particular child in relation to physical abuse, to that challenge back to parents and the people who are supposed to be protecting this child.
Q. Thank you. Just two more references in the document,

given time. Can we go at pages 48 to 49 to paragraphs 4.34 and 4.35, just briefly. So 4.34:
"Most professionals believed she was responding to the stresses of caring for a difficult child in difficult circumstances and not being abusive."
Do you see that?
A. Yes.
Q. Over the page, at 4.35, it says that there should have been an analysis, clear conclusion drawn from the available evidence and that simply didn't happen here. Just towards the end, four lines from the bottom, it says:
"In this case, the dominance of aunt alongside ineffective multi-agency practices and a lack of a clear framework for assessing potential physical abuse meant that practice in this area was not effective and it remains uncertain what the causes of the many injuries seen were."
I take it you accept that, from what you have just said?
A. Completely accept it, yes.
Q. There is one final point in relation to this Serious Case Review which I should raise with you, and that's at pages 63 to 65. The panel can go through it in full. But the central point, page 63, do you see the heading

"Lack of focus on the child and her lived experience"?
A. Yes.
Q. That whole section, doesn't it, criticises your department for not having a child-centric approach?
A. It criticises wider than my department, but that is a criticism, yes, I accept that.
Q. Do you see in paragraph 4.93 it refers to Child J being seen regularly?
A. Yes.
Q. So this isn't a child who wasn't being seen.
A. No, no.
Q. She was being seen?
A. She was seen very regularly.
Q. But the issues weren't picked up?
A. Yes.
Q. Over the page, at 4.96, importantly, do you see about halfway through the paragraph, it says:
"When children make disclosures they are asking adults for help. If they are being abused, they are taking a risk, as the disclosure might lead to further abuse. It is essential that professionals handle these disclosures sensitively, that children are reassured that they [did the right thing]."
Because this is a case where she had disclosed, in fact, hadn't she?

A. She had, yes.
Q. And it wasn't dealt with appropriately?
A. No.
Q. And she died?
A. Yes. So I think what -- as I say, we will give a much fuller response, because time doesn't allow. The areas that have been particularly picked up in this have been around looking at signs and symptoms of physical abuse, but also across the multi-agency, a significant amount of training and then follow-up audit activity to ensure that actually the child's voice is seen -- the child is seen, that the child's voice does come through records, be they social care records, health records, whatever, and we have real evidence of impact.
To go back to the Ofsted report that you were quoting from earlier, it is very clear in there that Ofsted were very clear that the voice of the child is heard and is very clear in all of our records.
I think the other thing that I would say that both the Serious Case Review and then the coronial process were very clear that -- obviously this was a terrible, terrible tragedy, when a child's life was taken, but that they did say that the attack that caused her to die could not have been predicted and her death could not have been predicted.

Q. We will also deal with that in more detail. There was another example which I wanted to give you, but I will have to deal with that tomorrow, given the time.
The third topic to turn to, just very briefly, because I think I have three minutes: independent reviewing officers.
A. Yes.
Q. Can I just ask that we deal with two points in relation to independent reviewing officers. Firstly, we may not be able to have it on screen, but I will give the reference. You have indicated you are familiar with the 2017 Ofsted review?
A. Yes, of course, yes.
Q. That found, didn't it, that independent reviewing officers in Nottingham City Council do not have the capacity to sufficiently monitor the progress of children's plans between review meetings, and it said that the IRO service responsible for the oversight and scrutiny of care plans does not have sufficient capacity to monitor the progress of plans in between their review meetings. It says that, doesn't it, at page 2 and pages 5 to 6 of the report?
A. It does, and to come back quickly on that point, that was something we'd identified and immediately following that we increased our IRO service. We increased it by

one and a half staff and also they are now all employed by us, we have no agency staff in our IRO service.
Q. Well, you say you had an immediate response, but this was also an area criticised in the March 2014 Ofsted report, wasn't it?
A. It was, and we increased --
Q. So why was there no improvement in the intervening three years?
A. There was a big improvement in the intervening three years, but the demand had continued to increase, so we increased following 2014, but we'd had to have a lot of agency staff at that point. By the time we got to 2017, we had less agency staff and we increased the capacity again, and I can now say that -- well, we immediately increased it by one and a half staff, which were agency staff, but now all of the staff on our IRO team are employees. We have recently had a peer review of our -- of our service that has confirmed that managers --
Q. I understand that some of that may be dealt with in this new statement which I haven't yet read so it may be we have to come back to that.
A. I'm not sure the detail of that is, but we are now more confident that we have sufficient capacity.
Q. Just one final thing.
A. Yes, sure.

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

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

time. I'm sorry for the Countdown-style time clocking as we were doing it, but thank you and I have nothing further.

Examination by MR SIMBLET

MR SIMBLET: Thank you, chair.
Ms Michalska, I am going to ask you about the process for dealing with civil claims. Normally, the council is notified of such a claim by a formal letter from a solicitor; is that right?
A. Yes, that's right.
Q. You have been very clear with Mr Sadd that the council's response to such letters and such claims is not affected by anything any insurance company requires you to do?
A. Yes -- well --
Q. So --
A. Let me be completely clear.
Q. Be very clear.
A. Let me be very clear. If there are certain processes you have to do, they will follow that. What I'm saying is, the decision about that claim is not impacted. So if an insurance company didn't want us to settle, and I said, "We will settle this", we will settle it.
Q. It follows, then, that the extent to which these claims are disputed is because the council is choosing to dispute them and, when they instruct lawyers to defend

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

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

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

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

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

therefore the matter that we would be apologising for is already a matter of public record. By not wanting to apologise publicly for individual cases, it's not for us to make public somebody's personal trauma and abuse. I think we have been very clear and I think Councillor Mellen was very clear yesterday that the process of this inquiry is all to help us understand the nature of the abuse that's happened over a period of time, and that -- in short, we are absolutely sure that at the conclusion of the process, there will be things that the city council will very much want to publicly apologise for. So it doesn't have to be a conviction.

MS SHARPLING: You have also indicated a number of initiatives that were put in place I think as a result of the inquiry, and to cite two of them, the notification process and also record keeping, you have appointed somebody to deal with that.

A. The record keeping is an absolute direct response from the work we have been doing and the inquiry, that's absolutely right. The notifiable isn't new, other than the need to keep a central record is the new bit, not the process, just --

MS SHARPLING: I see.

A. -- being able to interrogate it.

MS SHARPLING: That's not my exact question, if you let me

finish.

A. Sorry.

MS SHARPLING: I'm asking, why has it taken the inquiry to trigger these new initiatives?

A. It's taken the inquiry because I wasn't aware that, for example, when somebody wanted to see their information that that was just sent to them. I wasn't aware that we didn't already personally sit down and explain that to somebody and, similarly, I wasn't aware until we were asked a question about aggregating information out of notifiables, I wasn't aware that we weren't able to do that. So the inquiry has raised with me issues that, as a director, I did not know about.

MS SHARPLING: Thank you.

THE CHAIR: Just one question from me, Ms Michalska: regarding an aspect of your explanation about the city not having a dedicated historical abuse team.

A. Yes.

THE CHAIR: You seemed to stress strongly that you thought it was for -- it should be -- that such a team should be staffed by adult specialists.

A. Not all the team, no, but -- so in summary, in my understanding of the historic abuse team in the county council, it does a range of things, one of which is searches records which I think is a police task. The

other is their children's social workers offer support to adults. My view is, that part of the service should be delivered by adult social care.

THE CHAIR: I hadn't actually finished the question, which was, since you're in charge of both services, surely it was within your gift to set up such a team exactly as it should be configured, with a range of specialist services?

A. Well, we do have all of those specialist services. We provide the totality of the same -- with the exception of records -- as the county council does. We just don't have a dedicated team.

THE CHAIR: I don't quite understand why you don't have a dedicated team?

A. Because I didn't -- because I don't think that that was necessary to deliver the same quality of service.

THE CHAIR: I see. Thank you very much.

MR SADD: Chair, would you be content to resume at 2.00 pm?

THE CHAIR: Yes, indeed, Mr Sadd.

(The witness withdrew)

(1.18 pm)

(The short adjournment)

(2.00 pm)

MR SADD: Good afternoon, chair and members of the panel. This afternoon, the first witness the inquiry is hearing

from is Colin Pettigrew, a corporate county council witness. His statements are at NSC001235 and NSC001474.

MR COLIN PETTIGREW

Examination by MR SADD

MR SADD: Mr Pettigrew, good afternoon.

A. Good afternoon.

Q. You have provided two statements to the inquiry, as you heard me a moment ago saying. The first is dated July 2018. It runs to 165 pages and effectively carries out a review of both past and present policies and procedures. The second statement, dated 1 August 2018, is 34 pages. Both have come with extensive exhibits.

At the time that you signed these statements, I understand of course that the first statement will have been prepared on the basis of all sorts of information being provided to you, but you were satisfied that where you could speak to the truth of things, it was true as far as you were concerned?

A. That's correct.

Q. Are there any simple corrections that you need to make?

A. Just a very small correction, and I'm not sure where to take you in the document because we haven't had the preparation. I started working for Nottinghamshire County Council on 28 September 2015. However, I had

a two-week period of induction where I shadowed the interim director of Children's Services at that point, and actually my first date of being the statutory director would have been 11 October 2015.

Q. Thank you for that. The panel have a copy of your statements, and the whole statements will be uploaded onto the website. As you will have heard, by now, me say frequently, we are not going to go through the statements line by line or indeed page by page, but I am going to take you to particular topics which have been identified to you, and I may ask you to comment on documents which we will be bringing up on screen.

You are currently the corporate director of children, families and school services with Nottinghamshire County Council?

A. Yes, that's correct.

Q. We are going to go first to the topic of the notification that you are given of contemporaneous allegations of sexual abuse. Are you informed of all allegations of sexual abuse made in relation to residential or foster care within the county?

A. Yes, I am.

Q. Page 44 of your first statement, if we can go to that.

A. Yes, I'm there now.

Q. In fact, we need to go back a page, because we are going

to be looking at what is set out at paragraph 3c.iii.26. You say there on page 43:

"As director of Children's Services, I report to the lead member for Children's Services."

You say who the two vice chairs are. You say:

"In relation to allegations of sexual abuse, I report to the lead members when a current or former member of staff or foster carer is charged, appears in court or is sentenced ... "

Just reading on:

"The role of the elected members on receiving such reports is to seek assurance that other senior officers and myself are dealing appropriately with the matter and to provide appropriate challenge."

I should have read, just before that, that you say what you will report to the lead members are "any other matters that in my professional judgment need to be escalated". What criteria, please, Mr Pettigrew, do you apply in your professional judgment as to what should be escalated?

A. In response to this inquiry, which has shone a very bright torch on the work of the county council, and picking up on a question that Ms Sharpling asked earlier, we have reflected on why we didn't have a previously written protocol that gave a parameter for

me -- myself and Councillor Owen, and in early summer felt that this should be, yes, but that was a bit of a vacuum, but it was left entirely to my professional judgment.

Q. Mr Pettigrew, you have established criteria?

A. Yes, we established criteria and protocol and we submitted that as evidence.

Q. In that criteria, does that include informing about disciplinary cases which relate to child sexual abuse of children in care?

A. Yes, it would.

Q. Can we go, please, to tab 6 of the bundle, and this is document NSC001478. We are going to look at page 67 and then it includes pages 71 to 139. This was a case, Mr Pettigrew, in which a child was sexually abused by another child in residential care and an independent investigation found that the staff failed in their duty of care to the victim child. It also recommended that the department consider offering an apology and consider appropriate redress.

If we go to page 113, please --

A. Of my statement?

Q. No, of the document.

A. Right, sorry.

Q. We can see that that is the consequence of

the investigation, and under "Recommendations", the suggestion is, at 9.1:

"That A588 receives a letter acknowledging the failings that have been identified in this report.

"That the department considers offering him an apology for failing in their duty of care towards him.

"That consideration is given to appropriate redress ... in the light of the abuse he suffered whilst in the care of Nottinghamshire County Council."

That was on 7 October 2015. Do you recall when it is that you first found out about this case?

A. Yes, it wasn't at this occasion, it was subsequently. I can't remember the exact date, but I could provide that in writing, if that would be helpful. Yes, it was with regards to representation, yep, from his advocate, yep, his independent advocate, when he was -- I shan't say -- he was living in another part of England.

Q. I think it is right, if we go to page 133 of this part of the bundle, if that could be up on screen, this is a letter dated 11 May 2017. So from 7 October 2015 to 11 May 2017. This is you, if we go to page 135, we see that you have signed a letter.

A. I did.

Q. You were addressing it to A588 and you say:

"I'd like to thank you for your patience and

apologise for the time it has taken to write to you with a decision about your complaint."

The suggestion that had been made in 2015 was that the county apologised to A588. Can you remember why it took over 18 months from the date of the report to this letter of apology?

A. No, I can't, I'm afraid. Sorry.

Q. In fairness to you, some of the reasons are set out in that second paragraph of the letter. This was a case relating to harmful sexual behaviour --

A. It was.

Q. -- of a child in the care of the county. At the time, that is, 2015, that the investigation was completed, that the council accepted responsibility and that they were going to advise on obtaining redress, were you aware of harmful sexual behaviour as a significant issue relating to children in the care of the county?

A. No. I was aware of this case, and I can see now, and thank you for bringing it to my attention, that when Amanda Collinson had met A588, he raised further concerns with regards to how his complaint had been handled and how his case had been handled and Amanda gave a commitment to go away, and I think there is a full letter from Amanda that outlines a response to those things.

Q. You say, please, if we go to page 134 at part 6 of the bundle, at the top there, again, writing to this individual:

"I can assure you that in response to the investigator's second recommendation we have given careful consideration to the options available for an appropriate remedy for the harm you have suffered. We would be happy to support you to make a claim with the Criminal Injuries Compensation Board ...

"In addition, your request for compensation from the council for the harm and assault you have suffered will be met via Zurich, our public liability insurers. We have therefore logged a claim on your behalf and they will be in contact with you to discuss the process for settlement of your claim."

A. That's correct.

Q. More recently, at page 139, this is as recently as 2 August 2018, you're writing there to Amanda Collinson?

A. That's correct.

Q. You have revisited this person's case file and we can see that "the progress of his claim for compensation against us: this relationship has gone cold". Do you have that, four lines up from the bottom of the text?

A. I do.

Q. "Could I ask that you make contact with [this individual] via the Social Services Department. Encouraging him to re-establish contact with that solicitor or another firm to progress his claim."

Just a question to you. If we go back one or two pages to 136, September 2017, we see the solicitors putting in the claim. If you go to 137, we can see the insurers, Zurich I think it is, saying, "We will get back in touch with you once those investigations have been considered and we will carry out our own investigations into legal liability". Somewhere along the line, Mr Pettigrew, the original decision that this individual should get compensation and that you were encouraging him to make that application seems to have been lost, so that he was going through the process of actually having to make a claim and that the issue was still being investigated. Do you know how that happened?

A. I don't know whether that reflects that that has been lost. My understanding, and I may be wrong, again, because it is not my area, is that the young person would still have to go through the process. He is also a minor, and that, therefore, would need to be considered, I understand, through the court process. If I have got that wrong, I apologise, but that is my understanding.

Q. Your understanding is based on the fact that any damages that would be given to him have to be approved by the court. Is that what you mean?

A. That's my understanding, yes.

Q. Do you have freedom, Mr Pettigrew, to admit liability on the part of the council where you think it appropriate?

A. Where it's clear that we have failed a child or young person, I think I do. I think that the inquiry has heard from different tiers of the county council, from Rachel Morton to Steve Edwards to Councillor Philip Owen. It's our view that, where we have been found wanting, and in this case we absolutely were, we failed this young man, then we should move to settle quickly.

Q. Would that be something that you have to get the approval of your lawyers or insurers of, in writing -- so in writing that letter where you're saying, "You must make a claim, go through this process", would that have had to be approved by insurers and solicitors?

A. Within many local authorities, Mr Sadd, I think there is some confusion with regards to the relationship between legal and someone like myself, a corporate director. I will always ask legal for advice, but that's what it is, it's advice. It's for me to make a decision then as to whether I follow that advice, yep, and how I might

instruct those -- that legal department. Insurance companies I think are a different kettle of fish, and I think we do, with the greatest of respect, need to unpick some of this within the reparation investigation. There's certainly confusion as to tail and dog.

Q. One of the complainant witnesses, if we can move on, who gave evidence on Day 3, F37, gave evidence about being sexually and physically abused by F235, her foster father, in the 1970s. There were some records in relation to this, and she spoke about how she came forward to the council in 2015. The person case notes from October 2015 note the LADO's decision that there won't be a strategy meeting, given that two of the alleged perpetrators had died, and F37 was very critical of this decision.

We know from other documents that there were attempts to contact F37 to explain the position to her, but what I really want to ask you is a broader question, because we heard from Rachel Morton on Tuesday about what she considered to be an inconsistent approach being adopted by the county council in relation to the holding of strategy meetings and the reaching of an outcome in relation to allegations against perpetrators who were deceased. She thought that this should happen because it would be of benefit for the complainants.

Mr Pettigrew, do the county council now hold strategy meetings and aim to reach an outcome, that is, substantiated, unsubstantiated, et cetera, in relation to deceased perpetrators?

A. No, we don't. May I offer an explanation to that?

Q. I am going to ask you why you don't.

A. Okay, thank you. The genesis of the LADO strategy meeting, local authority designated officer, has its genesis within HR, human resource, procedures, and it's with a view to coming to a conclusion as to whether an allegation against someone in a position of trust has or hasn't been involved in the abuse of a child.

Part of the rationale behind those regulations or those guidance that was originally published within Working Together was -- so, for instance, where there was an occasion where a teacher had an allegation against him or her, and found themselves not at work, there was a process that would inform whether he or she should be allowed to return to work or should be dismissed that was outside of a criminal process.

I think what we have seen is that process begin to move into how we engage with victims and survivors or people who are alleging stuff. That has led to my view. Examples -- I think you've seen an example from the city council of really what I think are not good

examples of correspondence that's sensitive to victims' and survivors' needs.

Q. Can we go, please, to your first statement and to page 49 and to section 4. This is you addressing the way in which senior management with responsibility for children in care were held to account in practice. Do you have it now? It is page 49. It is under 4(a), the first main paragraph:

"Until the early 1970s, members held full direct responsibility for children coming into care and children in care ... council employees would have reported directly to the Children's Committee ..."

You conclude, having set that out:

"Therefore, through the 1970s and 1980s ..."

Do you have that, three lines up from the bottom of that paragraph?

A. I do, yes.

Q. "... as day-to-day decision making was increasingly delegated to officers, the role of elected members gradually became more of holding officers to account."

Having heard the evidence over the last three and a half weeks, and I think you have sat in on every day of the inquiry's hearings; is that right?

A. I have been here every single day, yes. I haven't managed to sit in every session. There's two sessions

out of the 28 or so that have happened that I have not been here.

Q. Do you accept that, having heard the evidence of core participants here, in practice, senior management were not held to account by councillors throughout the '70s and 1980s?

A. I agree with that. I agree.

Q. We are going to look at practice in the early 1990s, in the light of a very recent statement that has been provided to core participants. That statement is of Diane Kingaby and her report written in 1991. That's to be found --

A. Sorry, Mr Sadd? Are you going to take me to it, sorry?

Q. Yes, I am going to take you to tab 15 and tab 19. I just ask you this: have you had a chance to read --

A. I have. I received these early evening of yesterday, yes, and I apologise if my responses are either limited or restricted by that. However, if we can help further, we will add to any oral evidence I give in writing, as invited by yourself.

Q. At tab 15, we have a document written by her in 1991 where she sets out her experience of working in social work in the county. Then at tab 19, we have her statement to the inquiry about how that document came to be generated and her memory.

We go first, please, to tab 19, paragraph 3, please, the first page of her statement. She says that during councillor rota visits, about which the inquiry has heard a good deal of evidence, managers were told not to talk about contentious issues, and then we go to paragraph 4, over the page:

"Managers acted to avoid the Social Services Committee, knowing about the extent of abuse in children's homes, as they believed that the response would be negative."

The next paragraph down, the final sentence there:

"We were all instructed ..."

Do you have that?

A. Sorry, which page am I on?

Q. You're in tab 19.

A. I am.

Q. You're looking at the second page of the statement.

A. I only have one paragraph on that second page, if I'm on the same document.

Q. If we have it up, then, on screen, please, INQ002957.

A. That's the one I have. I only have one paragraph on my second page.

Q. Yes. It is now on your screen. I'm sorry that you haven't got the proper page, but if you look at what's on your screen, what I'm taking you to is the second

paragraph on that page that should be there, but it isn't. In the statement, she writes, and it's been highlighted:

"We were all instructed to tell social workers that they should try anything to avoid their child coming into residential care as they were more likely to be sexually abused than not."

I should add that Ms Kingaby was a senior professional officer at the time. Would you want to comment on what I have read out? Is there anything that you would want to reflect on?

A. You're asking me to immediately reflect on something I have never seen before.

Q. You haven't seen this? Forgive me. I thought --

A. No, I don't have page 2 in the bundle that you have provided me with.

Q. Perhaps you may be able to answer this question, though: in the course of meeting and investigating claims made in Daybreak and Equinox, can the panel assume that the council met with and discussed past practice with retired officers to understand better how things had worked in the past?

A. Yes, we have.

Q. Did you have those sorts of debriefings?

A. We have had those kinds of conversations during

preparation for the Independent Inquiry Into Child Sexual Abuse as well. It's unfortunate that this witness has come forward so late because that would have been helpful.

Q. I understand that.

A. Sorry, I was going to go on to say, I'm not trying to dodge your question --

Q. No, I understand that.

A. Ms Kingaby I understand to be someone who has worked for the department for -- she refers to leaving, but I think returned to work for the department for a long time. She's a credible witness, would be my view. If that's what she was writing contemporaneously, I would have no reason and no evidence to suggest that wasn't the case.

Q. I don't need to ask my next question then. Can we then go, please, to response to allegations against foster carers. Making you go all the way back now to your statement, please, page 41, and I want us to look at paragraph 3c.iii.17, the paragraph at the end of that page starting, "Where a decision is made to move or not move the children". Do you have that?

A. I do.

Q. We can see in the second sentence:

"Current placements may remain if discussed and agreed with the fostering services manager, the

fostering team manager and the service manager for the child. There would be no further children placed with the carer until the matter is resolved."

In what circumstances would it be appropriate, Mr Pettigrew, for the child to be left in the placement or for a child, I should say, to be left in the placement?

A. I think the -- under the exceptional circumstances that this would be the case, there would be senior management oversight, is what that paragraph reflects, that it wouldn't be made at a junior level, it would have to have management sign-off.

I would suspect -- if there was a situation, for instance, where a child had been abused by an older birth child of the foster carers, maybe an adult, and that that adult had been removed from the home either through being remanded in custody or being somewhere that we knew where he or she was, and we had the view that the foster carers had an ongoing strong relationship and commitment to the child that they fostered -- some of these foster placements last a long time -- and would be able to meet the emotional needs of that child and young person and were prepared to do so, I think that would be the kind of exceptional circumstances. But you're asking me a bit of "How long

is a piece of string?".

What I would want to emphasise, it would be the exception rather than the rule, and there would be some safeguards put around that with regards to senior management having oversight.

Q. I'm not going to ask you to go to this. I'm going to read it out to you, to help you. This is your second statement, page 28. It is paragraph 4h.14. There you are dealing with the issue of visits by placing social workers. You say this:

"The social worker must see and speak to the child alone, where able to do so. It is recognised that older children do not always agree to speak to their social worker. However, visits and reasons that a child has not been seen alone should always be recorded. The social worker should always give the child the opportunity to meet outside of the placement. This gives additional opportunities for the child to raise any issues with the social worker about the quality of the placement, who would then liaise with the supervising social worker and/or bring the concerns to the attention of the relevant manager, if required."

The first sentence of that paragraph, I will read it again:

"The social worker must see and speak to the child,

where able to do so."

That appears to be a qualification. Isn't it mandatory for the social worker to see the child alone?

A. We measure that, yes. It's good practice and it is a measure that our systems allow us to identify. Yes, we do case file audits on that and we inspect and critically assess ourselves against that.

Q. So where does the qualification arise in this paragraph, "The social worker must see and speak to the child alone, where able to do so"? That suggests there may be circumstances where the social worker won't be able to do so?

A. I think there will be circumstances where, on occasion, a social worker might not be able to do so. And on occasion, as you pointed out quite rightly, Mr Sadd, where the child or the young person expresses a view that they don't wish to do that. However, if it were the case on every visit, that would give us significant cause for concern.

Q. We can carry on back to your first statement, which you have open. I want us to look at paragraph 3c.iv.12. It is page 48.

A. I'm on that page.

Q. Where you say:

"in order to ensure independence, it is sometimes

necessary to commission external investigators to look into matters of concern."

You say this was done -- you say later on at 3c.iv.13, just below, this was done in relation to Patrick Gallagher's case. Mr Pettigrew, in your view, can independence ever be assured with an internal investigator? You say that in certain circumstances you will use an external investigator. Shouldn't the default position be always to use an external investigator?

A. There would never be an internal investigator with regards to a Serious Case Review, which Patrick Gallagher was. To help the inquiry, if I could also point out, the decision, who will be the independent author of a Serious Case Review, is not one that's made within the county council, it's one that's made by the independent chair of the LSCB. I think at c.iv.11, it begins talking about Serious Case Reviews. Two paragraphs further down, it's talking about an independent management review. So 11 would be a circumstance where Mr Chris Few would have identified an independent author, and 3c.iv.13, when it was a management review of NF77, that would have been a decision of Steve Edwards.

Q. Page 90 of your statement, please.

A. Sorry, Mr Sadd. May I ...?

Q. Go on.

A. We have mentioned A588, and on that occasion, the normal process would have been he made a complaint. That complaint should have been dealt with at stage 1 in normal process. Stage 1 would have been an internal investigation at as low level as possible, so a local manager. It was felt by Steve Edwards on that occasion that the allegations and the complaints were so serious it should skip stage 1, go straight into stage 2 of the complaint, and independent complaints investigators appointed.

Q. Page 90, please, paragraph 50.6. This is in relation to NO-F77. Following the allegations of abuse against him reference is made to giving "consideration to all children who had been placed with the foster carers". In the following paragraph, it's said that files were reviewed for all the children who had made allegations. Does this suggest, Mr Pettigrew, that the other children who had been in the placement did not have their files reviewed in this process?

A. No, Mr Sadd. You heard from Yvonne Dales that in both the Gallagher case and the F77 case, all children who had been placed there were given the opportunity to be seen and part of that being seen would have been

a review of files, I am sure.
Q. For instance, in 2000, when this case first came to light, albeit admittedly with allegations made by another child, and we know what the conclusion of that 2000 investigation was, we know that no other files were investigated, is it your view that they should have been, given the allegation being made?
A. In 2000, yes.
Q. 5o.8, so just over the page, please, this discusses the approach which was adopted as an alternative to the rotation of supervising social workers to regularly consider the record and scrutiny of the challenge being provided to social workers, and you may remember the evidence that was given on that and the discussion that I had with Jayne Austin in relation to that.
This management overview of supervising social workers, was made, as I understand it, operational in November 2012. Jayne Austin left in 2016 --
A. She did.
Q. -- and says she can't recall having seen the outcome of any reports prepared in the wake of this decision. How has this operated in practice?
A. I understand -- again, this predates me -- the conclusion was reached, having done a feasibility study, that we wouldn't move towards rotating social workers.

I think in my 35 years of social worker experience, there has always been an ongoing debate around rotation or not rotation. There is a view about the strength of building relationships and knowledge and organisational memory. We were inspected and fostering was part of that inspection in 2015, three years after this, and I understand the fostering service was found to be good by Ofsted externally. That inspection took four weeks with its inspectors. It was thorough and comprehensive.
The seven district fostering teams that Jayne Austin described, we identified, and one of those teams I understand, Mansfield, there were particular issues, and those issues were addressed through a management action plan and including management oversight. It was felt, I understand, that to change the entire structure on the basis of some failings that we found -- that we checked all fostering teams, but we found in particular one was not the way forward.
Q. Indeed, Mr Pettigrew, that's set out in her feasibility study and she sets out the impracticalities of rotational supervisory social workers, and the alternative is more stringent management oversight.
Do you know if there's in existence any systematic reviews carried out of that management oversight and how it's worked out in practice?

A. So we have added into this fostering service two additional independent reviewing officers who are responsible for the reviewing, the annual reviews, of our foster carers. Previously to that, it would have been done by the team managers within the service. We think that gives some additional independence. I'm sure we will revisit the whole notion of independence within the social work setting.
Q. It may be I'm not putting my questions very well. I'm not concerned so much with reviewing the foster carers themselves. I am concerned with the review and management oversight of the supervisory social workers who are attached to the foster carers. It is the need, which was recognised in the wake of the Mansfield issues, for there to be some scrutiny of that continuing relationship.
What we have been discussing is: no, we shouldn't have rotational supervisory social workers. Who is now -- or are you confident that what is now in place means that the need to supervise how placements are going, so far as the supervising social worker is concerned, is being properly managed?
A. Supervising social workers' line managers scrutinise the relationship and the approach of those supervising social workers.

Q. And they do so on a regular basis?
A. I understand they're supervised every month.
Q. That's part of a written report?
A. They would make a record of that supervision, yes, and, in turn, the line manager of the team managers would have supervision with those line managers and part of that focus would be their supervision.
Q. Are you aware of any supervising social workers who have been reassigned as a result of that review?
A. No, I'm not.
Q. Do you get provided with an annual report on the review of supervising social workers?
A. We're provided with the fostering service annual report, and that comes not only to my senior leadership team but also to the Children and Young People's Committee.
Q. That includes an item on the supervision of social workers?
A. I have to confirm that to you, yes.
Q. Can we look, please, at the approach taken to civil claims and apologies, please, in general. At paragraph 1.4 of your statement, page 2, you note:
"The county has received approximately 200 civil claims relating to sexual abuse of children whilst in our care."
One issue raised, Mr Pettigrew, by numerous

complainants is about claims being settled for what they perceive to be low offers. What considerations does the county take into account when coming up with a valuation of settlement offers?

A. My understanding is that that is negotiated between the county's solicitors and the claimant's solicitors.

Q. Do you have any input in what you consider to be just reparation for individuals who have been abused in care?

A. With regards to in terms of value? No, I don't. I'm advised by people that manage these areas, the risk and insurance, there's a whole range of elements considered. So, for instance, very recently, I have looked at the notional value of what we think a future claim might be worth. Indeed, it's with regards to A588. And I can see within that there's an amount for emotional harm, physical harm, potential future loss, but also for counselling within that. Now, I haven't seen that against another claim before, but I'm assured by my colleagues that that's as within previous settlements.

I have to say that I'm as frustrated with this process as anyone else. Within the context of this inquiry, I have been exploring with our risk and insurance colleagues this whole notion of loss against -- vis-a-vis harm. I'm advised that a young person who would come into a Nottinghamshire children's

home and experience -- be anally raped in the 1980s or '90s by a residential worker compared to a young person that might go to an independent Benedictine monks' fee-paying school and experience the same horrific abuse, that the level of loss that would be negotiated would be higher because of that individual's potential loss of income, career, et cetera. That's just scandalous, in my view, absolutely scandalous.

Q. One matter raised by Rod Jones in his evidence to the inquiry was about the role of insurers in responding to civil claims -- something we have already canvassed. At paragraph 1.6, still on that page of your statement, you say:

"For some periods, the county is insured. Insurers clearly have a financial interest in the claims and, if the claim spans an insured period, they will ultimately make decisions over whether or not to settle and the level of any offers. It should also be noted that for some periods the county does not have the benefit of insurance and claims falling into these periods are managed internally. However, claims tend to span a number of years. This usually means that there are a number of insurers and often self-insured periods involved ..."

At 7c.5, you say:

"Since costs are often borne by insurance companies, local authorities cannot unilaterally decide how a case is to be conducted, eg, settlement, limitation arguments and matters of proof."

Indeed, you have already touched on that with me this afternoon. What role, as you understand it, do insurers play in decision making regarding civil claims?

A. I think they're engaged with our risk and insurance department. They have conferences with -- as I understand it, and I have been to one of those conferences several years ago to observe them, where they considered those claims.

I do need to clarify a point, not from my statement, but where we are with regards to civil claims. What is within my sovereignty and the sovereignty of the local authority is where those claims, yep, are not insured, yep, and we are the party, so we are not working with a third party through insurance. In those cases, we will not be using limitation in future as a defence. That's within our gift and that's what we will be doing. So we will no longer be using limitations. We will also continue to work with that third party, our insurers, to encourage them to do the same. I met with our insurers in January of this year and had that conversation. They were still of the view collectively that limitation was

available within law and therefore it was something that they may fall back on or use.

Chair, I really think that this has got to be something that the inquiry considers with regards to insurance. This hearing, and we have heard today that these insurance claims are treated as other insurance claims. Tripping over a step in a council park is not the same as being in the care of the local authority and being grossly let down and sexually abused by an employee of the local authority. It is simply not the same, and limitation cannot apply in those circumstances.

If it was in my gift to instruct insurance companies, I would, and I would have done it a long time ago.

Q. Again with your first statement, paragraph 3c.iii.20, at page 42, this is in the context of discussing current practice. I will give you the opportunity to get there. Do you have it?

A. 42, I'm there.

Q. You say:

"On completion of the managing allegations process, a decision is reached on the outcome, eg whether the allegation is deemed to be substantiated. Responsibility for any disciplinary action is for the

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

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

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

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

for the investigation into the councils of Nottinghamshire have heard of a culture within units like Beechwood where you would not be surprised for that to be the case.

Q. Does anyone from the council assist adults with accessing their records and making requests?

A. Yes, we do. The council has the historic abuse team.

Q. Is psychological support provided or assistance with literacy offered at that time when records are being gone through?

A. If that's identified as being something to happen and, you know, we can -- I can identify a case where that is absolutely the case, and it wasn't just so that they could access records, it was because of that gentleman's circumstances, of us letting him down when he was in our care in the 1960s. When he should have been at school, he wasn't at school; his labour was being exploited.

We have helped him improve his literacy.

Q. In situations where we know at present a fee has to be paid for a subject access request, is the council reviewing how that might be waived in certain circumstances?

A. It may surprise you, Mr Sadd, that I wasn't aware that a fee was being requested from victims/survivors of child sexual abuse. If that's the case, I will make it

my priority to get that stopped.

Q. Page 88, please, of your statement, paragraph 5n.14. In the Gallagher case, one of the Serious Case Review recommendations related to support to the victims involved in the case. They were offered support and counselling. Do you know, Mr Pettigrew, what the takeup was for support and counselling.

A. I will confirm. I have it in my head that we are still in touch with six victims and survivors of that case.

Q. Do you know whether the council experienced that some of the victims, or any of the victims, had any reservations about accepting support from the council?

A. I don't know that.

Q. Can you understand how reservations might be expressed?

A. I would understand that, yes. One of the reasons that we, with some claims, have settled, including a fee for counselling, is so that the victims/survivors can go and find that support themselves.

Q. One issue that was raised with Steve Edwards is about continued funding of counselling for complainants. Are you in a position today to assure complainants that you will make every effort to continue to make funding available for as long as it is required?

A. Mr Sadd, you have heard Mr Edwards give that commitment, you have heard Councillor Owen give that commitment.

I am now going to give that commitment. If I may just refer to ciphers, after the evidence of L48 in Trent Bridge -- it is not the first time I have met L48. He is someone that we have an ongoing relationship with because of the contribution that he makes to our social work training. I met him and told him that as long as I'm director for Children's Services, if his therapist continues to identify him having need, then that's what will happen.

Q. As we identified a moment ago, you've sat in for every day of the inquiry bar two sessions. What is it you've learnt, Mr Pettigrew, from listening to the evidence that you hadn't realised or may not have appreciated?

A. I don't think I fully appreciated the strength of value that an apology can make for a victim and survivor. I have been humbled by the experience, and it's been really difficult for me and others. I heard D6, and, if I may, Mr Sadd, say, my legal team and I are of the view that the most articulate person that has been on their feet in this hearing is D6, and God forbid that we have a panel like this in 30 years' time, but if we do, he should be sitting where Mr Frank is sitting in 30 years' time. He is clearly a very able young man, and the local authority with responsibility for his aftercare and perhaps some of the people in this room now should

help him get back on his feet and get back on a path of academia. He is clearly a gifted young man.

What I would also, and I do want to say this, is that D6 -- and I can only assume it came from one of his legal team or someone in the team -- in describing the reaction at the end of Tuesday, the first Tuesday, Day 2, at Trent Bridge, described council officers as being "stoney faced". It wasn't my face that whoever communicated that to him was looking at, because if they were, they would have seen my lips tremble and my eyes fill. Nor was whoever communicated that to D6 with me in Asdas in West Bridgford when my wife phoned me and I tried to talk about the victim and survivor L -- no, it wasn't, apologies, I think it was C21, the gentleman who came in and said, "I entered this room as a victim, I'm leaving as a survivor". I couldn't get the words out. I sobbed in the aisles of Asdas.

Q. Mr Pettigrew, thank you for your patience with me. You are now going to be asked a series of questions by two different counsel representing core participant complainants.

A. Mr Sadd, may I at some point -- will I get the opportunity to respond to the suggestion that we have got it wrong in the county with regards to the historical abuse team? Or would you like me to put that

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

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

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

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

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

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

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

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

becoming more alive to harmful sexual behaviour. If we had more time --

Q. Could I just on that note -- I'm just conscious I have a question to ask and I'm going to get a note any moment saying "Stop talking", and I want to put this question. Is that okay? I'm sorry, because I do appreciate what you are saying.

A. No problem.

Q. Do you agree, Mr Pettigrew, that those historical failures included these three things: number one, social workers not seeing children alone? Do you agree --

A. Yes.

Q. -- historical failures, the evidence shows that? Secondly, allegations of possible sexual abuse or inappropriate contact not being taken seriously?

A. Yes, systemically, yes.

Q. Thirdly, poor record keeping and a lack of oversight. Do you agree they are three themes which have emerged from the historical evidence?

A. They were three themes which emerged from the historical evidence, yes.

Q. I take it you are aware of this -- it's in tab 18 of your bundle.

A. It is, yes.

Q. It is the August 2017 Nottinghamshire Safeguarding

Children Board report in the case of Perry, a neglect case. You're aware of that?

A. Yes.

Q. Can I take you to a few short paragraphs in relation to that. I'm conscious you may need to say something more detailed subsequently, but in the minute we have left, can I take you to some of it?

A. Yes.

Q. That's a case, isn't it, where the Serious Case Review was concerned with the appropriateness of professional support given to a 15-year-old boy diagnosed with serious injury in April 2015?

A. I'm sorry, but the report does not --

Q. Sorry, it is a 15-year-old child.

A. Thank you.

Q. A 15-year-old child named Perry in the report arising from emotional abuse and neglect?

A. Yes.

Q. Can I take you to a few paragraphs. It is INQ002951_032: it is paragraphs 171 to 173 here. First, Mr Pettigrew, paragraphs 171 to 173. Didn't the Safeguarding Children Board find that social workers failed to see the children alone and failed to act on the father controlling access to the children?

A. Ms Gallagher, if where you are taking me is to say,

"Does that not show that these three themes appear in this case?", I would say, yes, it does in this case. However, that's at the same period as this organisation was inspected by eight inspectors over four weeks. They didn't find that in the case. They found the children were being seen alone, in this case.

Q. So you say this is a failure in this individual case, it is not systemic. Is that your answer to this case?

A. Today, yes.

Q. Can you assist us just with this, given the time: the NSCB report, just one further paragraph that I will take you to quickly, it's paragraph 176 on that page. You will see why it is important for something later. If you can have 175 and 176 on the screen, it would be helpful. Paragraph 175 finds that serious allegations, a number of serious allegations, were not reported to the police by social workers in this case, doesn't it? Then paragraph 176, there is a specific issue there --

A. The most serious allegation that the child of rape was --

Q. That's where I'm going. Paragraph 176:

"The allegation of rape by one of the boys was discussed by the police and social workers although it was only social workers who undertook any formal enquiries ..."

That finds, doesn't it, that social workers were inappropriately delegated by the police to investigate and that that shouldn't have happened?

A. That's the finding of the Serious Case Review and I accept the finding of that Serious Case Review.

MS GALLAGHER: Thank you very much. I'm grateful for your time. I have nothing further.

MR SADD: Chair, I know it is envisaged that Mr Simblet is going to be asking some questions for ten minutes. I am conscious again of the time. Are you happy that he will allowed to continue?

THE CHAIR: Yes.

MR SIMBLET: Thank you, madam. I will be shorter if I can.

Examination by MR SIMBLET

MR SIMBLET: Mr Pettigrew, I'm asking you specifically about the civil proceedings involving L17. You have been to look back over those, haven't you, because I think you were describing that. She gave live evidence to the inquiry. She was sexually abused in Beechwood and Amberdale in the late 1970s and '80s, including being sexually abused by Colin Wallace. Now, Colin Wallace had been dismissed in 1980 and had been subsequently charged and convicted of abuse of somebody else, but was known to be an abuser. Is that right?

A. So I understand.

Q. Her letter of claim went to the council in 2011?
A. It did.
Q. It took six years until her claim was settled, didn't it?
A. It did.
Q. The council disputed everything, didn't it? It argued about limitation?
A. So I understand, yes.
Q. It required her to prove that she'd been abused, even though it was known that Colin Wallace had been a convicted abuser?
A. And that's wrong, yep.
Q. It disputed the psychiatric damage, and she gave evidence about that, didn't she?
A. So I understand.
Q. You say these things are wrong. It's been the consistent approach of the council in other cases, hasn't it?
A. It has historically, yes.
Q. You have signed defences requiring people to prove these things, supporting the defence of limitation and requiring proof of the abuse, haven't you?
A. When I first arrived, yes, I was given a bunch of defences to sign, yes. I have subsequently and since then on occasions refused to sign defences to that end.

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

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

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

A. I'm not suggesting you are, Mr Simblet.
Q. But you did, during that apology, make the complaint you have made now, that legal fees are often very expensive in these cases, didn't you? You said it to her during the apology?
A. I can't recall doing that. I'm reminded I'm under oath, but I genuinely can't recall doing that. Mr Ratcliffe, her solicitor, was present.
Q. You now are prepared to -- I think you've made an even broader guarantee than that in the evidence you have given this afternoon, so it may not be worth pursuing this point in detail, but you will support her, as you have offered, in any counselling and support that she needs going forward, and that's not just about your tenure, are you in a position to bind the council if you left?
A. No, of course I'm not. Actually, the question that Mr Sadd went, to the best of our ability -- I can't remember, I will check the transcript, but it wasn't an absolute guarantee and I'm not in any position to give that absolute guarantee. What I did offer L17 is, I would find her the appropriate way of finding a pathway to meet her needs. I have done that. I have continued to pursue that. I have confirmed my apology in writing.

Q. You have.
A. I am told by Mr Ratcliffe that L17 doesn't wish to receive that from him yet until the end of the proceedings.
Q. She is no doubt going to be grateful when she gets that. The counselling and support you will put in place as best you can when she is able to take it?
A. I will find her the correct way of accessing counselling and support. L17, you will recall, in her evidence has said she hasn't found counselling helpful to date.
MR SIMBLET: Thank you very much.
MR SADD: Chair, I wonder if you or your colleagues have any questions?
THE CHAIR: There is only one question, from Mr Frank.
Questions by THE PANEL
MR FRANK: I wonder if you could help me understand, I got a very clear sense from what you have said to us the frustration that you feel about the civil system of settling things being unsatisfactory, not just from the point of view of the claimant, which we have heard, but also from your point of view. You have found it frustrating when perhaps a defence is put forward which you don't think is appropriate. You have spoken about the clear view that you have about your relationship with your lawyer, namely, you will get advice from them

and ultimately it is your decision. But you also told us, and I think I recall you saying there was a question of some confusion about whether it was the tail or the dog, because -- is this the position, that you have been given to understand that, once a claim is made under what is sometimes called the legal doctrine of subrogation, the insurer steps into the shoes technically of the insured and then decides how the case is progressed? Is that the sort of thing you had in mind when you talked about the frustration you felt about that?
A. I think that's accurate, Mr Frank, yes.
MR FRANK: It would be helpful if you were able to do so -- not today, because you will need to reflect on it -- if you could give us a little bit more detail about that because, clearly, if you feel that, as an experienced and professional person, it may be that that's information that would be of help to us in coming to any conclusions we have about how the civil system may be improved.
A. Mr Frank, if it assists you, yes, I will do that in writing. The last thing that Nottinghamshire County Council wants to do is to be involved in another line of investigation by the Independent Inquiry for Child Sexual Abuse. We have had some association with

children in custody because we have a secure children's home and we have had some association with children migrants because of the sponsorship of the county council, the Children Migrant Trust. However, we think that our experience is so rich with regards to this area that we should be contributing to future seminars all around with regards to reparation.
MR FRANK: Thank you very much. I'm grateful.
MR SADD: Chair, that completes Mr Pettigrew's evidence.
(The witness withdrew)
MR SADD: Would you be happy to resume at 3.40 pm?
THE CHAIR: Yes. Thank you very much. Thank you, Mr Pettigrew.
(3.24 pm)
(A short break)
(3.40 pm)
MR SADD: Chair, the last witness of today is Chief Superintendent Robert Griffin. His statements are at NTP001536 and NTP001692.
MR ROBERT GRIFFIN (sworn)
Examination by MR SADD
MR SADD: Good afternoon, Chief Superintendent. You have provided two statements on behalf of Nottinghamshire Police. The first is dated May 2018, and the second is dated 2 July 2018. Both are signed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. No, it's not.

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

A. There should have been, yes.
Q. I'm going to take you through the case of D6, whom the inquiry has heard evidence from about the abuse he suffered in foster care. During his time in foster care, he was moved to Yorkshire and the Isle of Wight whilst under the care of Nottingham City Council. D6 said that he contacted the police last year when he had more information about what had happened to him. He informed the police that there had been previous investigations which had come to nothing. He said that the police wanted to take his statement, but he wasn't ready yet, and asked for more time. But in the meantime, the police officer spoke to the other children who had made allegations and invited the alleged perpetrator, NO-F70, for an interview, making him aware of the nature of the allegations made against him. He said -- this is D6:
"So any evidence of his interests, he had plenty of time to dispose of it, prepare a defence."
D6 went on to say that in June 2018, Notts Police passed the investigation to an officer in North Yorkshire Police, apparently having misunderstood that D6's abuse happened in the Isle of Wight, and D6 said this in evidence:
"It was just clear that it wouldn't come to anything

from the outset. There's just a fundamental flaw in how it's handled, particularly when you're in foster care and you're moved around. You're often out of county. The systems aren't built to accommodate the kind of investigation that needs to be accommodated."
Officer, what systems, if any, are in place to deal with cases that cross constabulary borders like D6's?
A. So we have Operation Hydrant, which is a national policing operation which was set up to co-ordinate and support British policing's response to non-recent allegations. Each time a report is made into a police service, the police service share that with Hydrant and one of their many roles is to ensure that they deconflict -- I will explain what I mean by that -- they deconflict reports being made in various police services so that a sensible agreement can be reached over which of those police services is to take primacy in the investigation.
Q. In your view, Officer, having heard these accounts in relation to L43 and D6, is there more that Notts Police could, or should, have done for them?
A. In relation to D6? I don't fully understand the various reports that D6 has made, but what I would expect is that any officer in Nottinghamshire who takes a report from somebody, even if that is to inform them that they

have investigations ongoing elsewhere, I would expect an officer to make contact with an officer in that host force, find out who it is that is investigating, and just ensure that that line of communication is confirmed before ceasing contact with the survivor. And I accept that that doesn't appear to have happened here, which is not good enough.
Q. From having observed the inquiry and seen some historical documents, do you think that the police historically view children in care as damaged individuals, so that allegations would not be taken seriously or properly investigated?
A. I think that the way that the police approach children in care now is just very, very different to the way that they approached children then. I try to put myself into the minds of officers back then, and it's difficult for me to understand. But there is a high volume of evidence that would indicate that that's how survivors felt.
Q. Outside of the existing specialist Child Abuse Investigation Unit and Operation Equinox, do you have any concerns that that attitude still exists amongst the police?
A. I don't have those concerns, no.
Q. Can we look at some findings in recent inspection

reports. At tab 3, there's NTP001510. The HMIC National Child Protection Inspection published in February 2015. This made a number of critical findings, Officer --
A. Sorry to interrupt you. Which tab am I?
Q. Sorry, tab 3. I should have watched to see what you were doing. It is my mistake. I want to go, please, to page 16, the third bullet point there. I will give you an opportunity to get there. The third bullet point reads:
"In a case involving an allegation by a 10-year-old boy in foster care that he had been sexually assaulted by another 10-year-old boy, there was no record to show that either of the boys had been spoken to by police, leaving them both at risk of further harm."
Then we go, please, to page 16, and -- sorry, still there. Below the third bullet point and penultimate paragraph, there are delays in limited case supervision:
"There were delays of three months or more in some cases sent to the Crown Prosecution Service for review and decisions on charging."
Page 28, the first paragraph. I will give you a chance to read there. That found:
"Although Nottinghamshire Police expressed commitment to child protection and inspectors found some

encouraging developments, much more needs to be done."
Then at pages 30 to 31 of the report, a number of recommendations were made, including greater attendance at Child Protection Conferences, reviews of supervision and management of child protection referrals, and that discussions should be held with the CPS to "improve timeliness of actions and decisions by both the police and CPS". That's page 31, the first line.
Then we go, please, to tab 4 of your bundle, keeping those conclusions in mind, and we look at NTP001512. This is a follow-up investigation completed by HMIC and reported in February 2016. This report found that important steps had been taken to implement some of the recommendations, but others had yet to be implemented. So if we go to page 10, please, and we look under "Summary of post-inspection review findings" and we go to the last sentence there:
"Inspectors were concerned to find that Nottinghamshire Police had not undertaken an audit of child abuse and sexual exploitation cases to improve standards."
Then at page 11, the third paragraph:
"We were concerned that nonspecialist staff such as front-line officers were investigating child protection cases without having received training in how to manage

them effectively."
Officer, in relation to that issue about the audit of child abuse and child sexual exploitation cases, has that since been done?
A. It has been done, yes.
Q. Are front-line officers still investigating child protection cases without having received training?
A. No, they are not.
Q. Following these reviews, we understand that the police produced the document at tab 6 which is NTP001538. We can see on the right-hand column under column "C", where it says "Recommendation status" -- do you have that? This is page 1, "National Child Protection 2014/2015 Recommendations"?
A. Sorry to interrupt, but can I just explain that the way that it appears in my bundle, the pages don't follow and it is not in A3, so I have actually brought a copy that puts it back onto A3.
Q. Okay.
A. So if you just talk me to where I need to be, please.
Q. That's helpful. We are simply on the first page of your A3, and we read across from left to right. We can see at the very top there are letters "A", "B", "C". Do you have that? This is at the very top. "A", "B", "C" representing the columns?

A. Unhelpfully, my A3 copy doesn't, but, yes, I can follow which is columns "A", "B", "C".
Q. It is a very simple issue, column C, "Recommendation status". We can see written in some of the boxes "closed"?
A. Yes.
Q. Where actions are closed, does it mean that they have been addressed?
A. Yes.
Q. Who monitors the progress of those issues having been addressed?
A. The deputy chief constable.
Q. What action has been taken, Officer, to improve the timeliness of charging decisions by the police and CPS in respect of child sexual abuse cases?
A. There's a fairly lengthy answer to this, because -- do I have the time to -- can I start and see how we go? Because what happened following this inspection is a whole review of our Public Protection arrangements in Nottingham. When I took over Public Protection in 2016, I read these reports then, and I have read them again recently, in preparation for this inquiry, and, frankly, the passing of time doesn't soften the blow when I read those documents. They are very disappointing.
So those recommendations since that time were dealt

with. We asked for a peer review to come and look at us to try and help support us in how we might implement these recommendations.
Very specifically on the subject of timeliness, timeliness was connected to investment of resource into Public Protection. There is a lot of reference in these documents to child abuse being under-resourced, and we put that right. We are fully engaged now with the CPS at various and including very senior levels --
Q. Can I help you along with your answer?
A. Sure.
Q. I don't mean to cut you short --
A. Not at all.
Q. -- but I'm conscious of the time?
A. Sure.
Q. My question to you was whether in fact timeliness had improved. Has it improved?
A. Yes, it has improved, yes.
Q. Has it improved to your satisfaction?
A. My satisfaction would be that once an investigation is complete, the file is delivered that day to the Crown Prosecution Service and they will be able to advise on that day, which is an unrealistic expectation. So I think that with the resources that we have and with the resources that the Crown Prosecution Service have,

I would say that, yes, they have improved to my satisfaction.

Q. I'm not going to get up on screen, but at tab 5, NTP001515, Lancashire Police carried out in August 2016 a peer review of Notts Police. They found "real strength" within the staff, "positive relationships" with social care from some teams, but they also made some criticisms.

A. They did.

Q. At page 9, the third paragraph, a criticism was:

"There is an apparent culture around Public Protection that officers who work on the teams are restricted or on reduced hours and work in a 'pink and fluffy' department."

Does that culture still exist?

A. No, I don't think it does -- sorry, let me rephrase: it most certainly does not, no.

Q. Still with page 9 and the third paragraph, the second line:

"It was clear that each and every team works in silos and there is little understanding about what staff in the Public Protection arena undertakes."

Again, does that remain an issue?

A. No, it doesn't. Can I just explain the context of this inspection?

Q. Yes.

A. This inspection, this peer-to-peer review, was asked for by me, and as a follow-on to the HMIC inspections at a time when I took over in the department. They were then used as a platform to completely restructure the Public Protection Department and one of the things that I set out to do, and I'm really confident that I have achieved, is that that whole silo working has now gone.

The department was considered to be a silo within the force, and areas of business within it were considered to be silos within silos. I think we have completely removed that, and the force now I think has a much more holistic approach to vulnerability, and that the right resource is deployed to the right offence type and investigation.

Q. Another criticism made, at page 12, for instance:

"Staff reported significant delays in sexual offences cases being sent to the CPS for review and decision around charges. We were informed that senior officers had raised such issues with the CPS but the problem continued."

Then, at page 17:

"Significant concern regarding staffing levels of the PP team."

Page 18:

"... staff dealing with child protection were under pressure and managing high levels of work, comments such as, 'We are waiting for something like Baby P to happen'; 'We feel at the bottom of the pile'; 'For the first time, I have noticed that people are unhappy'; 'Members of staff are in tears all the time' and 'People are looking externally for other jobs', appeared commonplace."

Has the morale improved?

A. Yes, it has. I don't fall out with or disagree with -- in fact, quite the contrary, I embrace all that is said in this peer-to-peer review and I feel, as a result of the restructure that followed, the vast majority of those things have been put right.

Q. This will include, presumably, in relation to page 10:

"It was of concern that there was no child sexual exploitation standard operating procedure or action plan in place."

Officer, we have heard evidence from complainant core participants about the approach taken to CSE when they were in care. Children who were being sexually exploited were treated in the past as offenders rather than as victims of crime. Do you accept, from what you have heard, that that appears to have been the case?

A. I accept that that was at that time the case, yes.

Q. Is there now a CSE standard operating procedure or action plan in place?

A. Yes, there is. It's described in some detail in our response to recommendations to the HMIC, which followed the inspection and then the subsequent peer-to-peer review. Can I take you to that? Would you like me to take you to it?

In short and simple terms, the answer is: yes. We developed from all of this work what's called a 4 Ps Plan, the 4 Ps standing for prepare, protect, prevent and pursue, and within each of those headers a whole series of actions in order to improve our response to child sexual exploitation. That came into play fully in 2016 and it is just an organic document which we keep working with and on.

Q. Can we turn, finally, to the issue of support for complainants as it exists now and in the future, including this issue that you will be very familiar with, having attended the inquiry, of liaison and communication.

Your statement sets out the policies in covering support for complainants of child sexual abuse, and, as you will have heard, evidence from complainant core participants is that they have not always been followed in practice, is how they feel.

What are the mechanisms for monitoring these policies of communication so that you are in a position to evaluate how well they are being used in practice?

A. Which policies are you referencing, sorry?

Q. This is in relation to support for complainants and contact with complainants.

A. Yeah, okay. So I think one of the challenges that we face still within our organisation is that we have got a lot of policies and a lot of procedures, and in each of them there is reference to support for survivors, there is reference to how we conduct investigations, and so on. But what we don't have is a singular reference document that talks about non-recent cases.

In terms of scrutiny around support now, I think we have got a really robust process which starts on a daily basis, where every case that comes into the organisation is reviewed by the DCI in their morning meeting, once a week by the detective superintendent, once a month in the operational performance review, once a month in the force operational performance review, and so that goes on up and through the organisation. I think, in addition to that, our victim satisfaction surveys that take place and also, from the multi-agency perspective, in sitting under the Children Safeguarding Boards, in the quality assurance subgroups, audits of these cases

that take place.

Q. Officer, where there are failures, are they best explained by a lack of understanding by officers in involved, by lack of time and resources or by other factors? What's your view?

A. I think there are many factors. I think what we have heard in this inquiry is that one size does not fit all. So we have heard some quite contrasting evidence on one particular point, for example, where -- in respect of the approach that we, the police, make when we want to go and make an approach to a potential victim/survivor. We have heard evidence from one victim/survivor saying that a cold-call, as it was described, from the police actually turned out to be the best thing that had ever happened to them, which is in stark contrast to another victim/survivor who said that it was the worst thing that could have ever happened to them.

So I think that probably constitutes a lack of understanding on our part, but I also think it's a really complicated issue, and hopefully something that might come out of this inquiry is some -- are some recommendations and some advice on how we might look to make that better for the future.

Q. Is there a protocol for notifying complainants of the updates on their cases?

A. So the Victim Codes of Practice gives us some guidance, and what it says is that victims will be updated regularly and that a victim contract will be drawn up.

Q. How long has that been in place?

A. I can't remember the exact year, but between five and ten years. What the code makes clear, and something we are really keen to follow, is that contact -- and that's the frequency and means by which -- needs to be agreed with the victim/survivor. So we have heard some evidence about victim/survivors being updated via text message, which, on the face of it, sounds incredibly unpalatable, but actually, that's what some victims/survivors prefer. Others meet in person, others by writing, others over the telephone.

Q. Officer, I am conscious there are others queuing up behind me to ask you questions. I'm going to end, so there are some questions I'm not going to be able to cover with you. I just wanted to know what steps, if any, have you taken to engage with victim and survivor groups?

A. Well, I took a decision to attend the victim/survivor group which, prior to that, there was no police officer in attendance. I couldn't understand why we weren't there, if I'm frank about it.

In terms of me being able to make decisions over how

we deliver our service, the service of the police service, what better way is there to inform that than to listen to victims and survivors, and that's why I decided to go.

Q. Are you still attending?

A. Yes.

MR SADD: Officer, you are going to be asked some questions. Thank you for your time.

Examination by MS GALLAGHER

MS GALLAGHER: Hello, Officer. As you know, I ask questions on behalf of 45 victims and survivors represented by Slater & Gordon, Instalaw and Bhatia Best, and I will be about ten minutes, just so you are aware.

The first thing is, you were asked earlier by Mr Sadd about training, and you said you would welcome a specific training package. Could I just ask you something very particular about that? As we understand it, a number of police forces now use children who have been detained in police cells, in training, when they are trying to understand children's engagement with the criminal justice system. Do you agree that a similar system with survivors of child sexual abuse would assist the police in understanding and improving its standards and consistency and practice and also indeed building trust?

A. I can see that there is a part to play for victims and survivors in helping us to develop training packages, yes.
Q. Thank you. The second thing I just want to touch on concerns a very particular issue. You have obviously been here every day. You will be aware, Officer, of course, that there have been some delays in updating complainants, including some core participants here?
A. Yes.
Q. You accept, do you, that some of your officers have failed to keep complainants updated on the progress of investigations, including, indeed, a number of those who were due to give evidence in week 1. I'm thinking in particular of P16.
A. That I've agreed that they failed to keep them updated?
Q. You agree there was a failure in keeping P16 updated in relation to the progress of his investigation?
A. Sorry, yes. Yes.
Q. Thank you.
A. Sorry, yes, absolutely, yes.
Q. I'm conscious you have accepted it privately. You understand why, for the record, we wanted to establish it?
A. Quite.
Q. In the table -- I think you have a table which

summarises those who haven't given oral evidence and haven't had their evidence read. It is at your tab 15. I don't ask for it to be pulled up, given the time. But have you had a chance to go through that, Officer?
A. The table?
Q. The table.
A. I have read the table several times, yes.
Q. I'm grateful. You will have seen in that that there is a number of people who say that they haven't been updated, including D33, D5, P18 and P15 and D10. You have seen those?
A. Yes, I have seen those, yes.
Q. So you accept that there has been a problem in some cases with keeping people updated?
A. Yes, I do agree with that, yes.
Q. Thank you. What steps are you going to take to address that?
A. I am going to take all of what I have heard and learnt from this inquiry back into our organisation and just reiterate that message. The policies and procedures are there for us. They make it -- they are pretty clear. They are not difficult to follow. But policies and procedures are worthless without proper leadership and that's what I intend to commit to when I go back into the organisation.

Q. Thank you, Officer. Now, earlier in questions from counsel to the investigation there was some discussion about the issue of trust. Can I just ask you some issues in relation to that. You were obviously present for the read evidence in week 1 in which P3 and D46 described in some detail their lack of trust in the police. Just to remind you, it said P3 has not disclosed her abuse to the police. That's P3 having been abused in the 1970s in Vale View, as she says:
"My current support worker advised me not to report to the police because she felt the police would let me down. I have heard lots of bad things about how the police have handled people's cases, so I don't know if this is something I want to put myself through."
Similarly, D46 has not reported abuse to the police, abuse in Farmlands in the 1990s by older boys. He says:
"I feel like nothing has changed. It would still be my word against theirs."
Do you accept, Officer, that this lack of confidence/trust in the police remains a barrier to disclosure for P3, D46 and others?
A. I agree. I agree that lack of trust and confidence is a barrier, yes.
Q. We heard in answer to some questions from Mr Sadd earlier your reference to some steps which have been

taken, including the dedicated non-recent child abuse investigation team. Are there any specific proactive steps that you're taking to deal with people like P3, D46 and indeed many others in that table that you will have seen?
A. Well, I think it goes much wider than those individuals. I think that the survivor group has been a great leap forward for us in terms of building trust. I think that some of the issues that have been illuminated during this inquiry, such as, how do we approach victims, how do we keep victims updated, all those things we would really welcome support and guidance going forward, and I think if victims and survivors could become involved as almost critical friends in helping us with that, that would serve to improve trust.
Q. Officer, one question: a lot of your answers in relation to that refer to the survivor groups. I represent quite a few people who aren't in a survivor group, they are individuals. They have described in that table not feeling able to come forward. Are there any proactive steps taken in relation to them who aren't in a survivor support structure?
A. For those people individually?
Q. Yes.
A. Is that what you are asking? I would welcome

a discussion with each of them to try to talk that through.

Q. Thank you, Officer. The next thing also relates to trust. Is there any specific training or particular policies within your force about dealing with complainants, so child abuse victims, adults or children, who themselves have significant criminal records?

A. There aren't any policies, no.

Q. Is there a recognition that those individuals may have particular additional difficulties in trusting the police and that may cause additional difficulties to them in making disclosures?

A. I think victims and survivors who have criminal records, it's fairly obvious they have encountered the police and will see the police as people who investigate crime and lock criminals up. It must be difficult, therefore, for them to see us as people who are likely to listen and support, so I can understand that, yes.

Q. Thank you. So recognition but no specific policy. Is that a fair summary?

A. Yes, I think that's fair.

Q. The next issue does involve a document. It is again the table which I think you have there in tab 15. It is page 7. This relates to a particular individual, D42.

It may help to have it on screen if it isn't readily available for people. It is INQ002574. It's one of those where the text goes off the page, if you remember. I just wanted you to have it to hand. It is over towards the right, a little further along.

So D42's experience of the police, Officer, has been very poor. In summary, she disclosed her abuse to the police in 2006 but a decision was taken not to charge. She's repeatedly attempted to get the case re-opened and the result of that is that your force issued a harassment warning against her for her attempts to get her abuser prosecuted. Are you able to say whether you think that's an appropriate way to treat a survivor of abuse? I think it is the wrong page which we have up on screen, excuse me. Thank you. It's here. Thank you.

A. It is a very difficult question for me to deal with, without knowing the context of that case.

Q. Of course. You may just not be able to answer now. Could I have a commitment that you can look at it and answer us later?

A. I think probably a sensible way forward would be, subject to the agreement of that victim/survivor, that we sit and have a conversation with them and try and understand. Understand what went wrong and whether we can put that right.

Q. I'm grateful. There is one other issue about D42 which we may have to roll into that too. That is that D42 lawyer's were told this year, in the last few months, that her 2007 statement was lost, probably destroyed, by your force which she found very distressing. Again, is that something you can look at and speak to D42 about?

A. Yes, absolutely.

Q. Can I then ask that we pull up on screen a document which you will have seen earlier when I spoke to Mr Pettigrew. That's the Perry Serious Case Review. You're aware of that?

A. I am aware of it, yes.

Q. Could I ask we pull up INQ002951. Paragraph 174, first, on page 32.

A. Which tab am I with now? Oh, it's on the screen.

Q. Have you got it?

A. I've got it on the screen. Do I need to find it as well?

Q. I think probably on screen may be easiest. Just there, you will see paragraph 174 refers to several occasions when information was recorded indicating siblings could be at risk from inappropriate contact or relationships. If we go over the page, there is a long list. Can I just point out a few of these. You will see (a), if you look at (a):

"The youth worker reporting information ... to the MASH ... that sibling 1 was talking with a 60-year-old male via a social networking website."

Do you see that?

A. Mmm-hmm.

Q. And (c), a reference to an allegation of rape. (g), a reporting about a posting on a social networking site of a comment about having sex "with dad", and then (h), a reference to lying in bed there with another person.

Is it right, if we look down, then, at paragraph 175, that the vast majority of those incidents were simply never reported to the police by Social Services?

A. Much like Mr Pettigrew, I only received this document late last night and, in all honesty, I haven't had a chance to read it and digest it properly, which I would welcome the opportunity to. Could I perhaps respond to those at a later time? It's difficult, on the face of it, for me to --

Q. There are two separate issues.

A. Okay.

Q. One of them is, just so you know what the two points are. The first one is why you weren't told, and that's obviously primarily a question for Mr Pettigrew and for social workers. The second issue relates to

paragraph 176, and this is something I raised with Mr Pettigrew earlier, which is, one matter which was reported to the police, the Serious Case Review found, was the allegation of rape by one of the boys, and the finding in the SCR is, it was only social workers who undertook formal inquiries and it was inappropriate for the police to delegate that to social workers. Is that something you will look at, Officer?

A. Yes, I can look at that.

Q. Thank you. Finally, this is the last matter, and I will do it very quickly, there was a discussion earlier with Mr Sadd about the issue of texting people, how difficult it is to make a decision about how you deal with people and how you engage with people. Just a couple of points relating to that.

The first point, Officer, I think you will accept, having been here, that many of those specific examples are not people who are upset because, unbeknownst to the police, the process that was adopted wasn't one that they wanted, it was because the process which was adopted by the police was expressly contrary to what they had asked?

A. That certainly sounds to be the case, yes.

Q. Just following on from that, in evidence this week DI Dales said there is no protocol addressing how best

to make initial contact with people identified as potential victims of abuse. It is up to officers' individual judgment. Given the level of distress that you have heard here, do you accept that there should be a better system than individual officers taking a decision without guidance in circumstances where, as we have heard, many of them get it wrong?

A. So there are actually several sources of guidance, but they're not consolidated.

Q. Yes.

A. So there is guidance in the Hydrant SIO manual, there's guidance in the rape and serious sexual offences procedure, the child abuse -- lots of different references in lots of different policies, but I agree, a --

Q. You think it would help to strand tie?

A. A single and consolidated version of how best, I would welcome, yes.

Q. A strand tying protocol, in essence, which would cover both the initial cold-call in whatever format --

A. Yes.

Q. -- and also dealing with people who want to be updated about ongoing progress in their cases?

A. I would agree with that, yes.

MS GALLAGHER: Thank you very much, Officer. That's all

from me.

MR SADD: Chair, do you or your colleagues have any questions?

THE CHAIR: Ms Sharpling?

Questions by THE PANEL

MS SHARPLING: Thank you, Mr Griffin. Just one question from me. The Victims Code is being enforced in various iterations for a number of years now, I think. In all that time, has any management action been taken against individual officers or members of staff or any disciplinary action for failure to comply with it, to your knowledge?

A. I'm really unable to answer that, I'm afraid. It's something I can go away and find out. Our Professional Standards Department would hold that information. To my knowledge, no, but it's possible that it's the case.

MS SHARPLING: Perhaps you would be so kind to find out?

A. Absolutely.

THE CHAIR: Thank you. Sir Malcolm?

PROF SIR MALCOLM EVANS: Thank you. At the outset, in response to a question from Mr Sadd, you said that you considered there to be no reluctance on behalf of the police to investigate. Do you think there is any reluctance to prosecute?

A. No, I don't think there's a reluctance to prosecute.

That's the headline answer. I think it's a really interesting discussion around the police opinion on when something is ready to prosecute versus when the CPS considers something is ready to prosecute, because we apply a very similar test, in fact almost identical test, so the Full Code and the public interest. It isn't until those two tests are passed that we would take a case to the Crown Prosecution Service. So it seems, I think, logically to follow that, at that point, we, the police, are of the opinion that the case ought to be prosecuted, but lawyers look at it through a very different lens, and so they should.

I thought the evidence of Sue Matthews, either yesterday or the day before, I think she explained that test really well, the fact that she's bound by it. But it was one of the points that I was really hoping to get out, that where a decision is taken by the CPS, which, if it is a "no further action", is not going to accord with the victim/survivors' wishes -- of course it's not -- and it's my job and the job of my officers to go and explain that, which we do, and we have to do, in line with the code and with the law, but I wanted the victims and survivors to know that when we offer that explanation, we don't expect them to accept it, because it's really difficult, because where they have suffered

the abuse that, without question, these survivors have, and they're brave enough to step forward and describe what's happened to them and the outcome of that is that the person who has done that to them is not going to be prosecuted, how could an explanation from somebody like me ever be acceptable to them? It's a really difficult challenge, I think, that we face. But I wanted them to understand that, from my perspective, we don't explain it expecting them to accept, but that's the explanation all the same.

PROF SIR MALCOLM EVANS: Thank you.

THE CHAIR: Thank you. There are no further questions. Thank you very much.

MR SADD: Chair, that completes the evidence of today.

(The witness withdrew)

MR SADD: Chair, just to remind you, tomorrow for closing speeches and there is one witness tomorrow morning and the inquiry, exceptionally, tomorrow is starting at 9.30 am.

THE CHAIR: Thank you very much.

(4.47 pm)

(The hearing was adjourned to Friday, 26 October 2018 at 9.30 am)

INDEX

PAGE

D

T